9. The right to health

Alicia Ely Yamin

Health rights are in many ways the most complex of rights to theorize and promote through advocacy, as they challenge views of what is natural and normal both in social and in bio-legitimated constructs, as well as demanding that we contest the boundaries of what have been considered the traditional realms of law and politics. Health is deeply and inextricably intertwined with other rights, both civil and political as well as economic, social and cultural; it is also dependent on interpretations of equality and issues such as trade and fiscal policies that relate to economic governance; and, ultimately, the advancement of health-related rights depends upon both the legal and the health systems in a country.

This chapter provides a broad overview of select issues relating to the right to health as it has been elaborated in international law. However, effective theorization and advocacy require an understanding of the interplay and recursive relationship between national and international norms and institutional dynamics. In any specific context, the relation between health and drivers of patterns of health and ill-health that lie beyond the health sector (as well as, often, beyond national borders) implicate distinct regimes of law, institutional frameworks and procedures for advancing health rights, understood as a precondition for social equality and inclusion, as well as part of democracy.

The chapter proceeds as follows. First, it sets out some theoretical starting points for working on the right to health and health-related rights, which are a critical foundation for understanding the nature of the right and making cogent interpretive arguments with respect to the relevant norms under national, regional and international instruments. Second, it highlights selected aspects of normative evolution in the UN treaty-based human rights system, as well as in a variety of different kinds of charter-based law in relation to health rights. Third, the chapter provides a very brief overview of the treatment of health issues and the right to health in regional human rights systems. Fourth, it notes some of the other bodies of international law that are relevant to understand in advancing health rights.

Space precludes any attempt to be exhaustive in this chapter. Rather, I have selected a very few cases, General Comments and other materials to illustrate particular aspects of health-related rights. As suggested throughout, research and advocacy in this area should start from the premise that these norms are open-textured and inherently contested, in terms of both distributional effects and ethical implications, and therefore call for deliberation in legislatures and courts. Thus, the chapter seeks to raise issues for consideration, rather than to dictate what inevitably would be overly facile approaches.

1. OVERVIEW: CRITICAL CONCEPTS

1.1 Meaning of Claiming a 'Right to Health'

Health has not historically been conceptualized as a right, nor is it treated as a legally enforceable right today in many countries. Thus, in constructing the normative contours of the right through legal arguments, it is critical to understand the conceptual implications of treating health as a right and not to merely enumerate positive treaty norms or soft law as though they were either self-evident in their interpretation or automatically authoritative.

First, the right to health is not a right to be healthy, which would be absurd. Nor is it a right to all medications and treatments one might need. Asserting that health is a right as a conceptual and philosophical matter implies first that it has special value or moral importance. In a modern rights paradigm, that moral importance stems from the inextricable connection health has to a life of dignity.[1] Because health has both intrinsic and instrumental importance to dignity, inequities in health are arguably normatively more troubling than, for example, inequities in income, as income is purely instrumental to a good life.[2] That is, health is not only itself essential to enable people to carry out their life plans, and in turn to live a life of dignity; it is also difficult to imagine living a flourishing life that includes other rights and aspects of self-government or full participation in one's society without some basic preconditions for the enjoyment of health. In short, in Amartya Sen's capabilities framework, health allows people to enjoy certain essential functions and capabilities; in Norman Daniels' Rawlsian framework, health, including health care, preserves a range of fair equality of opportunity.[34]

A second implication – and precondition – of claiming a right to health is that health is subject to societal influence – not just biological accident or individual luck.[5] It does not make sense to speak of a right to anything that is not the result of social and institutional arrangements. Think, for example, of the absurdity of claiming a right to be a talented cook or dancer, or a right to have a good singing voice or physical agility. While these 'gifts' or 'talents' are undoubtedly influenced by wealth, the ability to support training and the like, their contours are not inherently shaped by societal forces. As an empirical matter, not just health *care* but the distribution of health and ill-health has been shown to be deeply affected by power structures – class, gender, race and the like – in society.[6] Further, questions of political economy centrally affect the distribution of health and disease within and across societies.[7] As these asymmetries of power reflect policy choices at multiple levels, they can be changed by concerted human

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[1] Norman Daniels, *Just Health: Meeting Health Needs Fairly* (CUP 2008); Amartya Sen, 'Why and How is Health a Human Right' (2008) 372 The Lancet 2010; Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why They Matter* (U. Penn Press 2016) 73.

[2] Arthur Kleinman, *Writing at the Margin* (UCP 1997).

[3] Daniels (n 1).

[4] Amartya Sen, 'Elements of a Theory of Human Rights' (2004) 32 Philosophy and Public Affairs 315.

[5] Sen (n 1).

[6] Yamin (n 1).

[7] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (UCP 2003) 29–51.

decisions, thereby shifting patterns of health. That is, if health is in large measure socially constructed, it can be socially reconstructed.

It is worth underscoring that, in making claims about changing societal influences on health in order to promote health rights, advocates and scholars are implicitly contesting what is often accepted as *natural*, whether in patterns of health and (ill) health, or categories of normality and deviance. Think, for example, of caste-based disparities in mortality in India, or questions regarding autonomy and entitlement to interventions of non-cisgender persons. Contesting the status quo sometimes requires creative and anti-formalistic interpretations of law, based both on empirical evidence and normative arguments regarding understandings of equality and dignity.

1.2 Social and Political Determinants of Health v Medical Care

Both structural factors affecting health outside the health sector and health systems per se are subject to societal influence. Abundant empirical evidence from epidemiology shows that health is a close reflection of patterns of (in)justice in society, based on class, social constructions of race and gender and sexual identity, among other things. Further, 'social determinants' are responsible directly and indirectly for a far greater proportion of health and ill-health than medical care. Social determinants of health are defined as 'the conditions in which people are born, grow, live, work, and age',[8] and include the enjoyment of other rights, such as freedom of movement and information, and rights to education, housing and decent work.

However, health systems are themselves social determinants of health.[9] As with all rights, the right to health requires a just arrangement and functioning of social institutions. The health system – which encompasses both public health goods and health care – is a central social institution in a democratic society. Thus, the financing, priority setting, regulation and normative oversight involved in the health system are crucial to evaluating whether and how a state is protecting and promoting the right to health.[10] This includes labor laws and treatment of health workers, which is often neglected in health rights advocacy despite playing a significant role in the possibilities of realizing the right.

Similarly, political determinants of health, defined by the Lancet-Oslo Commission in 2014 as the 'norms, policies, and practices that arise from transnational interaction', increasingly play an outsized role in global patterns of health, as well as the financing and delivery of health care.[11] Some mechanisms of such political determinants include austerity policies imposed by international financial institutions, the indirect and direct health impacts of climate change disproportionately produced in the economic North and borne by poor populations in the global South, the propagation of harmful gender stereotypes through social and other media and the extractive activities of transnational corporations, including the tobacco, alcohol and sugar industries.

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[8] World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO 2008) 26.

[9] Sen (n 1).

[10] Alicia Ely Yamin, *When Misfortune becomes Injustice* (forthcoming SUP 2020).

[11] Petter Ottersen O et al., 'The Political Origins of Health Inequity: Prospects for Change' (2014) 383 The Lancet 630.

1.3 Human Rights-based Approach (HRBA) to Health v Right to Health

For advocacy, it is essential to distinguish between a claim to a legally enforceable right to health and a Human Rights-based Approach (HRBA) to health, which is inherently multi-sectorial and diffuse, precisely because health is affected by so many other factors. The principles underlying an HRBA to health are drawn from the 2003 UN Common Understanding of a Human Rights Approach to Development Assistance and include accountability, transparency, participation, equality/nondiscrimination and the rule of law.[12] Subsequent elaboration of these principles has focused on enabling legal and policy frameworks, multisectoral strategies and plans of action, transparency and equity in budget formulation and execution, effective and fair program implementation, monitoring and evaluation that permits disaggregation and actionable information for social accountability and remedies, which include but go beyond judicial remedies. HRBAs to health also stress the need for international assistance and cooperation, and increasingly the extra-territorial obligations of donor states and other actors.[13]

The line between a right to health and an HRBA to health is a tricky but necessary one to navigate in both strategic advocacy and theorization. Without any distinguishing of what can be carved out as the right to health, that right is inclined to swallow other social determinants and other rights that are essential for a life of dignity. In so doing, the right to health also becomes unenforceable.

On the other hand, it is essential to contemplate in scholarship as well as advocacy the broader drivers of health patterns, which, as discussed, go well beyond the health sector. Without doing so, health matters are likely to be treated as they often are in vertically integrated programs, as isolated modular issues, disconnected from questions of social equality and democracy.

1.4 Contested Contours: Evolving Technologies, Epidemiology, Demographics

The parameters of all rights are, by nature, contested, and vary across contexts and time. All rights evolve with technological changes; for example, the right to education as well as freedoms of expression and information have evolved with the growing importance of digital domains. However, perhaps more than any other right, the boundaries of an enforceable right to health, which includes health care as well as public health preconditions (such as water and sanitation) under international law, must be constantly revisited in any given context due to ever evolving technologies as well as economic, epidemiologic and demographic trends. What was once acceptable treatment for tuberculosis, schizophrenia, or any other condition changes, given biomedical advances (as well as other factors, such as drug resistance).

Similarly, in order to adopt *appropriate* or *reasonable* measures under international or domestic law, a country is expected to react to evolving threats to human health, which are affected by aging populations, climate change and immigration patterns as well as disease outbreaks and the rising incidence of non-communicable diseases across the world. Finally, social

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[12] United Nations Development Group, 'The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies' (UN 2003).

[13] HRC, 'Technical Guidance on the Application of a Human-Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality' (2 July 2012) A/HRC/21/22.

drivers of health conditions or lack of access to care are subject to evolving social as well as legal norms, such as stigma based on sexual orientation and gender identity.

Moreover, it is not just through directly protecting a constitutional right that health rights are implicated. Theorization through law requires constantly creating narratives and analogies, which then require adaptation. For example, that a person's body is her property has implications for issues such as abortion, but it also has implications for the genetic material obtained from blood and saliva samples, and even skin cells sloughed off without our awareness.

In short, scholarship and advocacy around health rights inherently entails calling for duty-bearers to justify laws, policies and programs in light of a background of constant change. Thus, research and advocacy often call for challenging the boundaries of an existing norm (in constitutional law or other branches of law). In turn, doing so can require enlarging spheres of political deliberation with respect to how health entitlements are financed and distributed. For example, in neoliberal economies that increasingly rely on informal labor, differentiated benefits schemes based on employment status can lead to structural discrimination, including against spousal and child dependents.

2. UNITED NATIONS (UN) SYSTEM

Article 25 of the Universal Declaration of Human Rights (UDHR) sets out a right of everyone to

> a standard of living adequate for the health and well-being of himself [sic] and of his [sic] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [sic] control.[14]

In 1948, the Universal Declaration was promulgated without dissent as a common standard for all humanity; however, it is questionable to assert that every Article in the UDHR has become jus cogens under international law. Nor is the UDHR a treaty that binds states parties in specific ways; it should not be cited as though it were.

2.1 UN Human Rights Treaty-based System

2.1.1 International Covenant on Economic, Social and Cultural Rights

The core formulation of the right to health under international law was set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), promulgated in 1966 (entered into force in 1976). Paragraph 1 establishes that states parties 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Without defining health, paragraph 2 then sets out that 'the steps to be taken … to achieve the full realization of this right' include: (a) reduction of the stillbirth rate and of infant mortality, and the healthy development of the child; (b) environmental and industrial hygiene; (c) prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

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[14] Universal Declaration of Human Rights (adopted 10 December 1948) (UDHR) Article 25.

It is important to note a few elements of this formulation. First, the right to health under international law includes both public health preconditions, such as environmental or sanitary measures, and access to medical care for all. Second, the measures to achieve the right to health necessarily imply *freedoms* (such as bodily autonomy) as well as *entitlements*. Under the ICESCR, unlike the International Covenant on Civil and Political Rights (ICCPR), the right to health was subject to progressive realization in accordance with the maximum extent of a country's available resources. This distinction with the ICCPR is significant in that it has been used to justify treating health as a programmatic aspiration as opposed to an enforceable legal right. Nonetheless, in reality, all rights – civil and political rights and ESCR – are progressively and continually realized; it is counterproductive to think of the achievement of rights as static endpoints. Third, under Article 2 of the ICESCR, states parties are to seek international assistance and cooperation to realize the right, and donors are supposed to provide 'assistance and cooperation, especially economic and technical', to advance the realization of the right, along with other economic and social rights. Note that this language does not commit donor states to any particular level of economic assistance, although political declarations have attempted to set out threshold levels. The Office of the High Commissioner for Human Rights (OHCHR) and the Inter-American Commission on Human Rights (ICHCR), as well as non-governmental organizations such as the Center for Economic and Social Rights, have developed structure (such as laws), process (such as resources and policy efforts) and outcome indicator frameworks to assess whether states are progressively realizing health and other ESCR.[15]

The original formulation of the right to health under the ICESCR is clearly outdated today; for example, it fails to even mention reproductive health. Subsequently, the content of the right to health has been elaborated on significantly under international law, through General Comments and observations of treaty-monitoring bodies (TMBs), as well as through jurisprudence. The CESCR's General Comment No. 14 on the Right to the Highest Attainable Standard of Health was issued by the Committee in 2000, and followed a series of other General Comments that sought to clarify the content of specific rights.[16]

A few points are important to note. First, General Comment No. 14 updated important aspects of the ICESCR, including clarifying that the right to health requires 'measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information'.[17] Second, the CESCR's inclusion of

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[15] Organization of American States, Comisión Interamericana de Derechos Humanos 'Lineamientos Para La Elaboración de Indicadores de Progreso en Materia de Derechos Económicos, Sociales y Culturales' OEA/Ser.L/V/II.132 (19 June 2008); Center for Economic and Social Rights (CESR) 'The OPERA Framework – Assessing Compliance with the Obligation to Fulfill Economic, Social and Cultural Rights' <www.cesr.org/sites/default/files/the.opera.framework.pdf>; Office of the High Commissioner for Human Rights (OHCHR) 'Human Rights Indicators – A Guide to Measurement and Implementation' HR/PUB/12/5 (30 March 2012).

[16] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (11 August 2000) E/C.12 /2000/4.

[17] Ibid para 12.

> the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health[18]

should be construed, in my view, as underscoring that the right to health is not limited to health care and that health is affected by social factors and power relations, including gender, class, caste and race relations. On the other hand, as noted above, it is important to make clear that the right to health does not swallow all other rights on which it is interdependent, so as to reinforce that the right – as opposed to a broader multi-sectorial HRBA to health – can be clearly circumscribed and judicially enforced.[19]

Third, General Comment No. 14 deployed the structure and various frameworks that had been used in other General Comments by CESCR. One such framework is the so-called AAAQ model of the inter-related elements of the right to health, meaning that health facilities, goods and services (including those relating to public health preconditions of health) be available, accessible, acceptable and of adequate quality.[20] In particular, 'accessibility' included physical and economic accessibility and accessibility on the basis of non-discrimination, and the inclusion of accessible information in order to make health-related decisions.[21] Other TMBs have also adopted this framework and set it out with respect to specific aspects of those treaties.[22] Advocates should consider how these four elements interact for specific populations, and how barriers faced in people's lived realities, such as bureaucratic barriers and delays, constitute failures to achieve AAAQ.

A second framework used in General Comment No. 14 – respect, protect, fulfill (RPF) – sets out that health, like all rights – civil and political rights as well as ESCR – entails obligations by states parties to respect by refraining from direct infringement (such as discrimination), protect against third party interference (such as pollution) and fulfill through positive legislative and other measures (such as extending health coverage).

Fourth, in General Comment No. 14, the CESCR set out an extensive list of core obligations.[23] In 1990, in General Comment No. 3 on the Nature of States Obligations, the CESCR argued that 'a State party in which any significant number of individuals is deprived of … essential primary health care … is, prima facie, failing to discharge its obligations under the Covenant'.[24] General Comment No. 14 adopted a very different approach with the lists set out in paras 43 (a–e) and 44 (a–f), which has been justifiably critiqued for failing to 'offer a principled, practical or coherent rationale', as John Tobin has written.[25]

Scholarship and advocacy asserting that these constitute minimum core obligations should recall that CESCR's claim to authoritative interpretation of the ICESCR is defeasible. Notably,

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18 Ibid para 1.
19 John Tobin, *The Right to Health in International Law* (OUP 2012) 56.
20 CESCR (n 16) para 12.
21 Ibid paras 12(c) and 27.
22 CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (Women and Health) (1999) A/54/38/Rev.1 para 22.
23 CESCR (n 16) paras 43–45.
24 CESCR, General Comment No. 3: The Nature of States Parties' Obligations (14 December 1990) E/1991/23 para 10.
25 Tobin (n 19) 240.

the ostensibly 'non-derogable' nature of these obligations has subsequently been walked back even by the CESCR itself. Further, those courts that have adopted minimum core obligations have not used General Comment No. 14 as a starting point, and advocates working in countries with defined packages in health systems would be better placed to begin there. Moreover, other courts have rejected a minimum core approach in favor of a reasonableness review in which General Comment No. 14 remains a factor. Above all, in asserting obligations as part of a minimum core, advocates should take care that they are not undermining progressive realization in practice, which requires advances along all the obligations to respect, protect and fulfill.

CESCR's General Comment No. 22 on the Right to Sexual and Reproductive Health is arguably a more useful starting point for legal and social mobilization regarding the right to health, and updates aspects of General Comment No. 14 in ways that apply beyond sexual and reproductive health. General Comment No. 22 first states clearly that 'The right to sexual and reproductive health is an integral part of the right to health enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights', but also that 'It is also reflected in other international human rights instruments'; second, distinguishes between underlying determinants of health (such as water and sanitation) and the far broader range of social determinants, as discussed above; third, provides a far more coherent list of core obligations, including ensuring 'access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health'; and fourth, emphasizes the significance of international obligations, including refraining from actions that interfere with the right, beyond merely providing aid.[26]

As General Comment No. 22 from CESCR makes explicit, General Comments that address health specifically should be read in conjunction with the other relevant General Comments. Those from CESCR include General Comment No. 12 on the Right to Adequate Food,[27] General Comment No. 15 on the Right to Water,[28] General Comment No. 17 on protections for interests in scientific and other production,[29] General Comment No. 19 on the Right to Social Security,[30] General Comment No. 20 on the meaning of equality and non-discrimination,[31] and General Comment No. 24 on human rights and business entities.[32] The meaning of aspects of the right to health should also be interpreted in light of existing soft law guidance from other TMBs, regional treaties and jurisprudence from supra-national tribunals, with an eye to the harmonization of international law.

As described in Chapter 2, the Optional Protocol to the ICESCR, allowing individuals to bring petitions for violations by states parties, entered into force in 2013. In March of 2019, in

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[26] CESCR, General Comment No. 22: The Right to the Highest Attainable Standard of Health (4 March 2016) E/C.12/GC/22.

[27] CESCR, General Comment No. 12: The Right to Adequate Food (12 May 1999) E/C.12/GC/12.

[28] CESCR, General Comment No. 15: The Right to Water (20 January 2003) E/C.12/GC/15.

[29] CESCR, General Comment No. 17: The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from any Scientific, Literary or Artistic Production of which He or She is the Author (25 November 2005) E/C.12/GC/1712.

[30] CESCR, General Comment No. 19: The Right to Social Security (4 February 2008) E/C.12/GC/19.

[31] CESCR, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (2 July 2009) E/C.12/GC/20.

[32] CESCR, General Comment No. 24: State Obligations Under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities (10 August 2017) E/C.12/GC/24.

SC and GP v Italy, the CESCR found that (1) the transfer by an in vitro fertilization clinic of an embryo into S.C.'s uterus, against her will (she subsequently miscarried the embryo), and (2) the lack of clarity of the current legal provisions regarding the right of women to waive their consent to the transfer of embryos after fertilization, constitute a violation of the petitioners' right to the highest attainable standard of health. The CESCR highlighted several concepts which are worth reiterating: (1) the right to health contains both freedoms and entitlements and cannot be reduced to any package of services; (2) compliance with the right to health must be interpreted in light of obligations regarding non-discrimination/substantive equality on the basis of gender; and (3) any limitations on the right to health must be compatible with the 'nature of the right', under Article 4 of the ICESCR – the law regarding implantation of fertilized embryos was deemed not to be so as it was, inter alia, opaque in the protections that it afforded and discriminatory as a de facto matter.

2.1.2 International Covenant on Civil and Political Rights

The right to health is intimately connected to the right to life, which is defined as a civil right under international law and a fundamental right under national constitutional law. Under the ICCPR, the right to life has evolved from the right to be 'free from acts and omissions that are intended or may be expected to cause [a person's] unnatural or premature death' to a more capacious understanding of the conditions that are necessary for a person to enjoy 'a life with dignity'. General Comment No. 36 updated General Comments Nos. 6 and 14,[33] which had been issued in the 1980s. The extent to which the Human Rights Committee, which supervises compliance with the ICCPR, enlarged its understanding of the right to life is perhaps most evident with respect to abortion rights, where the Committee notes that

> States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable.

In addition, states parties may not regulate pregnancy or abortion in all other cases 'in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly'.[34] Given that the status of abortion has been hotly contested at the national level, as well as in international forums, this determination of the scope of the right to life focusing on the life and suffering of the woman is notable, and a significant shift from earlier Human Rights Committee jurisprudence.

Another significant area for the construction of health rights under the ICCPR – especially given the numbers of forced migrants in the world today – is in relation to those who may not be legal citizens or permanent residents of a given nation, but are nevertheless human beings. In 2018, the Human Rights Committee found in *Toussiant v Canada* that, regardless of legal

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[33] HRC, General Comment No. 36: Article 6 (The Right to Life) (2 November 2018) CCPR/C/GC/36; CCPR, General Comment No. 6: Article 6 (Right to Life) (30 April 1982) HRI/GEN/1/Rev.1; CCPR, General Comment No. 14: Article 6 (Right to Life): Nuclear Weapons and Right to Life (9 November 1984) E/C.12/2000/4.

[34] CCPR (n 33) General Comment No. 36.

status, migrants are entitled to emergency care in situations where their lives could be at risk or their health irreparably damaged.[35]

2.1.3 Convention on the Elimination of All Forms of Discrimination against Women

Women's enjoyment of health depends upon non-discrimination across a wide range of other rights. Nonetheless, two Articles in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted on 18 December 1979, are of particular relevance for health. Article 12 commits states parties to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning'. However, it also recognizes that women's biological health needs require differential treatment in order for them to enjoy the right to health on an equal footing with men, as a matter of substantive equality in practice.

As women's health is deeply affected by traditional practices and gender norms, it is also important to recognize that in Article 5, CEDAW calls for eradicating harmful traditional practices.[36] Arguably, the CEDAW Committee has interpreted these practices in ways that exotify or condemn non-Western practices, such as female genital cutting, while not paying nearly as much attention to such issues as the high prevalence of cosmetic surgery in certain countries. Thus, this remains a space to reconstruct understandings of diverse manifestations of patriarchy, and their impacts on health, across cultural contexts.

In 1999, the CEDAW Committee issued a General Recommendation on 'Women and Health', which followed other, narrower recommendations on aspects of women's health and took up many of the ideas that had been set out at important UN development and human rights conferences in the 1990s.[37] In that General Recommendation, the CEDAW Committee discussed both discrimination against women and differentiation among women based on class, ethnicity, and similar.[38] Advocacy on health rights in general – not just women's health – should note that intersectional forms of discrimination and disadvantage, which include disability, displacement and age and the like, must be understood not as additive but as a confluence of factors that shape any given person's ability to carry out a life project.[39]

Under the Optional Protocol to CEDAW that allows for individual petitions, the CEDAW Committee has issued a number of ground-breaking decisions on health. One worth highlighting in particular is the *Alyne da Silva Pimentel v Brasil* decision, which related to the maternal death of an Afro-Brazilian woman in a health facility outside of Rio de Janeiro.[40] In that case, the CEDAW Committee: (1) enforced a state's obligations to ensure affirmative entitlements to emergency obstetric care, as a matter of nondiscrimination against women; (2) analyzed intersectional discrimination on the basis of race, gender and class in the instant case; and (3) clarified states' duties to regulate private actors in the health sector, as part of the duty to protect women's rights to health and life.[41] The *Alyne* case is an excellent example of how what

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35 CCPR *Toussaint v Canada* (24 July 2018) CCPR/C123/D/2348/2014.
36 CEDAW (adopted 18 December 1979) Article 5.
37 CEDAW Committee (n 22) para 3.
38 Ibid para 6.
39 Ibid.
40 CEDAW Committee, *Da Silva Pimental v Brazil* (25 July 2011) CEDAW/C/49/D/2008.
41 Ibid.

was once considered a natural if lamentable reality was converted into an issue of political and legal obligation: as Rebecca Cook wrote, 'Maternal deaths can no longer be explained away by fate, by divine purpose or as something that is predetermined to happen and beyond human control … when governments fail to take the appropriate preventive measures, that failure violates women's human rights.[42] Further, for scholarship and advocacy in this area, it is important to note that the duty to regulate private actors extends the applicability – and in turn the significance – of the decision far beyond the realm of maternal or reproductive health.

2.1.4 Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC), adopted on 20 November 1989, both elaborated on the specific obligations of states parties with respect to children's health – children being defined as under 18 years of age, with rights conferred on children even when domestic children's codes only go up to the age of 12 – and set out conceptual frameworks for the implementation of those rights. Article 24 of the CRC takes up some of the language in the World Health Organization (WHO) Constitution's preamble defining the 'right to the enjoyment of the highest attainable standard of health' and goes on to assert that it also includes access 'to facilities for the treatment of illness and rehabilitation of health', to which states parties shall strive to have no child deprived access. The steps states parties should take include measures: (a) to diminish infant and child mortality; (b) to ensure the provision of necessary medical assistance and health care with emphasis on primary health care; (c) to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution; (d) to ensure appropriate pre-natal and post-natal health care for mothers; (e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; and (f) to develop preventive health care, guidance for parents and family planning education and services.

The CRC also calls for the abolition of traditional practices prejudicial to the health of children, as CEDAW did with respect to women, and for international cooperation specific to health. The CRC lists a wide array of other relevant rights of children in relation to health, including the right to life. By encompassing survival and development of the child, the CRC opens possibilities for expansive interpretations of civil and political rights to promote child health. Conversely, the CRC includes civil and political rights that are essential to the protection and promotion of health rights, such as the right to official registration of an identity, which, inter alia, provides access to health and social protection benefits. The Committee on the Rights of the Child (CRC Committee) has also issued multiple General Comments that address, directly and indirectly, various dimensions of children's health, and specific Comments in relation to HIV and Adolescent Health in 2003 and the right to health in 2013.[43]

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[42] Rebecca J. Cook, 'Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision' (2013) 41 Journal of Law, Medicine and Ethics 109.

[43] CRC Committee, General Comment No. 15: The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (17 April 2013), CRC/C/GC/15 Article 24; CRC Committee, General Comment No. 3: HIV/AIDS and the Rights of Children (17 March 2003) CRC/GC/2003/3;

But perhaps the most important contributions made by the CRC and CRC Committee in relation to health rights are the twin concepts of 'evolving capacity' and 'best interests' of the child. The concept of evolving capacity recognizes that a child of five may require far more protection and guidance from parents and other social structures than an adolescent, who also requires freedoms and agency to take decisions such as those involving sexual activity. In turn, the concept of 'best interests of the child' requires that decisions made on behalf of the child can be justified to the child and in light of normative standards. This applies to decisions taken by parents and guardians, such as whether a child should undergo a particular medical treatment, as well as a decision by a state, such as provision of contraception or other care. The best interests standard cannot be capriciously or inconsistently deployed. For example, in *JAB v Spain* (2019) the CRC Committee found that the state had violated the best interests of the child of a Cameroonian migrant child in relation to the right to health in assigning a guardian to the petitioner to ensure he received vaccinations and specific treatments, but providing no representation in a deportation context to determine whether he was a minor or an adult.[44]

2.1.5 Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD), adopted on 13 December 2006, is extraordinarily important to conceptions of health. First, the CRPD defines disability as resulting 'from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others',[45] thus adopting an understanding of disability that rejects the biology/anatomy-based individualism of the biomedical model. Thus, both the drivers of disability and the penalty of a particular disability, whether physio-motor or psycho-social, are not intrinsically related to the pathology or condition. Rather, they are deeply influenced by social responses. For example, we take for granted that babies cannot walk in the same way as adults and we make social accommodations; we do the same thing for elderly people. It is only for adults in a certain age bracket that we view the accommodations that they require as 'extra'. Similarly, a person born with a disability –whether physical or psycho-social – in a low-income country often faces far greater obstacles to living a life of dignity than a similar person in a high-income context.

In Article 12, the CRPD went further than the 'best interests' standard set out in the CRC, establishing a new standard for equal protection before the law of persons with disabilities. Under Article 12, legal capacity required a 'supported decision-making model', including in crisis situations when the individual might otherwise be judged to have an impaired mental state, and therefore opened the door to 'substitute decision-making' under other treaties, including in accordance with 'best interests' under the CRC.

Advocates and researchers in this area should be aware that this standard is contested. Some see seeking out the 'best interpretation of the individual's will', as opposed to the traditional 'best interests' standard, as having the potential to expose people living with intellectual and psycho-social disabilities to abuse or exploitation. Others have questioned whether it is

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CRC Committee, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (21 July 2003) CRC/GC/2003/4.

[44] CRC Committee, *Convención sobre los Derechos del Niño J.A.B. v España* (31 May 2019) CRC/C/81/D/22/2017.

[45] CRPD Preamble.

practicable, especially in low-resource settings. Human rights advocacy in the psycho-social disability context has tended to focus on flagrant abuses in facilities;[46] global health and development discussions have in contrast focused on unmet needs for mental health care.[47] In short, there is little academic – or policy-making – discussion that bridges these fields or reconciles the theorization of the right to health with standards of legal capacity in the disability context.

2.1.6 International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted on 21 December 1965, defines 'racial discrimination' as

> any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.[48]

The relationship between race and health rights is important to understand for both scholarship and advocacy. Under human rights law, it is simultaneously understood that: (1) race is a socially determined construct, not merely grounded in biological or genetic differences; and (2) arbitrary differential treatment based on perceived differences in skin color affect real people's health in complex ways, which manifest through matters such as segregation in housing and other social determinants, as well as discrimination within health systems.

Article 5 of the ICERD sets out a very brief inclusion of states parties' obligations to eliminate discrimination in 'public health, medical care, social security and social services'.[49] In 1996, the UN Committee on the Elimination of All Forms of Racial Discrimination (CERD) issued a General Recommendation expanding on the dimensions of Article 5.[50] Concluding Observations of the Committee have brought into sharp focus the racial discrimination that pervades health systems in much of the world and results in not just abuses but also deprivations of health rights and disparities in both access and outcomes. Further, it is relevant in our current geo-political context, where immigrants are reflexively othered and disparaged, to note that the CERD has explicated how national origin can be used as a proxy for race to impose the same discriminatory stereotypes as well as arbitrary or coercive measures. For example, in *L.G v Republic of Korea*, the Committee found that the state had discriminated against the petitioner and violated her right to health by subjecting foreign teachers to a series of medical tests (including HIV, opiates and, without her consent, a syphilis test).[51]

In short, this section has provided an overview of relevant major treaties in relation to health rights, as well as interpretive guidance by TMBs and jurisprudence. However, there

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[46] See Disability Rights International, 'Comments and Suggested Revisions to the UN Committee on the Rights of Persons with Disabilities Draft General Comment No. 5 On the Right of People with Disabilities to Live Independently' (30 June 2017).

[47] World Bank Group and World Health Organization, *Out of the Shadows: Making Mental Health a Global Development Priority* (World Bank and WHO 2016).

[48] ICERD Article 1.

[49] ICERD Article 5.

[50] CERD, General Recommendation No. 20 on Article 5 (14 March 1996) A/51/18.

[51] CERD, *L.G. v Republic of Korea* (1 May 2005) CERD/C/86/D/51/2012.

are numerous other international treaties, as well as non-binding UN declarations, that bear on specific populations' health-related rights, including ILO Convention 169 on Indigenous Communities and the UN Convention on Migrant Workers.[52] To be clear: researchers and advocates in this area should always map the terrain of intersecting norms and mechanisms, international as well as regional, that relate to the specific issues that are under study and the needs of populations that are being advocated for.

2.2 Charter-based Organs and World Health Organization

2.2.1 UN General Assembly

Health rights are inordinately shaped by the parameters of UN development agendas. This has been true historically, from the transformative possibilities created in UN trans-sectorial conferences in the 1990s to the technocratic and vertical approaches of the Millennium Development Goals (2001–15).[53] It is also true today under the Sustainable Development Goals (SDGs), which provide a blueprint for global development from 2016 to 2030.[54] Those 17 SDGs apply to rich and poor countries alike, target inequality as well as poverty, and are intended to be read as inter-dependent. Thus Goal 3 specifically addresses health, and universal health coverage (Target 3.8) has been given extraordinary prominence. Nevertheless, other SDGs, including but not limited to gender equality (Goal 5), reducing inequalities (Goal 10) and access to effective institutions (Goal 16), are also relevant for advancing health rights. The SDGs are 'soft law' but nevertheless are addressed by TMBs, often in concluding observations, and play an important role in shaping policy and funding environments for health – particularly in low-resource, highly aid-dependent countries, but elsewhere as well.

2.2.2 Human Rights Council

The Human Rights Council (HRC), a charter-based organ of the United Nations with 53 member states, has adopted multiple resolutions that bear on health-related topics, in addition to playing an important role in suggesting alignments between international obligations and policy in relation to health. Beginning in 2012, the Human Rights Council adopted 'Concise Technical Guidances' on HRBAs to health in the context of maternal mortality and morbidity, child survival, family planning and other matters.[55] However, the Human Rights Council has also adopted resolutions that affect health directly and indirectly and are far from progressive, such as a resolution on the traditional family in 2015.[56] HRC Resolutions should be read as providing complementary interpretive guidance, especially in terms of aligning legal and policy frameworks with programs, which is the principal objective of universal periodic

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[52] Convention Concerning Indigenous and Tribal Peoples in Independent Countries (adopted 27 June 1989) International Labor Organization 76th Session; International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (adopted 18 December 1990).

[53] United Nations Millennium Declaration (adopted 18 September 2000) UNGA Res 55/2.

[54] Transforming Our World: The 2030 Agenda for Sustainable Development (adopted 25 September 2015) UNGA Res 70/1.

[55] HRC (n 13).

[56] HRC, 'Protection of the family: contribution of the family to the realization of the right to an adequate standard of living for its members, particularly through its role in poverty eradication and achieving sustainable development' (22 July 2015) A/HRC/RES/29/22.

review by the HRC. However, these resolutions and accompanying guidelines should not be seen as conclusory statements as to what the law *is*.

2.2.3 World Health Organization

Unlike other specialized agencies of the United Nations, the WHO is both a technical agency and a norm-setting body of the United Nations. The 1946 preamble to the WHO Constitution set out:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. 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.[57]

Although featuring in the preamble, this definition has been taken up in many UN documents subsequently, and is critically important in that it challenges the very narrow biomedical paradigm – which understands health as 'the absence of disease or pathology'.

The two most important examples of the WHO's norm-setting role in relation to health rights are: (1) the Framework Convention on Tobacco Control (FCTC);[58] and (2) the International Health Regulations (IHR).[59]

2.2.4 Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC), which entered into force in 2003, is the first and only treaty negotiated under the auspices of the WHO. In contrast to previous drug control treaties, the FCTC emphasizes 'demand reduction' as in regulation of marketing and claims. Note that the FCTC does not establish a TMB, as in human rights. Disputes are often taken to investment tribunals. For example, in 2010, Philip Morris International launched an arbitration under the 1998 Switzerland–Uruguay bilateral investment treaty against Uruguay's tobacco control measures. In 2016, the International Centre for Settlement of Investment Disputes released its decision in favor of Uruguay with respect to all claims and recognized that regulatory authorities, when making public policy determinations in contexts such as public health, enjoy a 'margin of appreciation'.[60]

2.2.5 International Health Regulations

The current 2005 version of the IHR, which entered into force in 2007, was substantially revised in light of SARS and other increasing threats to public health that transcended borders in an ever globalizing world.[61] The IHR binds all members of the WHO but is sometimes argued to be a treaty as opposed to a charter-based instrument, because of the form in which it is written.[62]

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[57] Constitution of the World Health Organization (adopted 15 February 1946) UNGA Res 131.

[58] World Health Organization, Framework Convention on Tobacco Control (adopted 21 May 2003).

[59] World Health Organization, *International Health Regulations*, 2nd edn (WHO 2005).

[60] Harold Koh, 'Global Tobacco Control as a Health and Human Rights Imperative' (2016) 57 Harvard ILJ 433.

[61] WHO (n 59).

[62] Lawrence O. Gostin et al., 'The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development' (2019) 393 The Lancet Commissions 1857.

The underlying purpose of the IHR is 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade'. However, the protection of people's rights – from unduly coercive measures to travel restrictions – is an important aim in the IHR as well. The IHR also call on states to strengthen core health capacities and for international assistance and specific efforts at collaboration in supporting resource-poor states in doing so. This intersects with language in human rights law regarding the right to health.[63]

3. REGIONAL HUMAN RIGHTS SYSTEMS

Theorization and advocacy regarding health rights cannot fail to consider the particularities of regional human rights systems. The Inter-American System, the European System and the African System have all developed a significant body of norms relating to health rights and have their own set of institutions and procedures for reviewing state compliance with treaties, setting out broad declarations regarding policy matters and responding to individual petitions. It is beyond the scope of this chapter to review these different systems in any depth. However, the fault lines in conceptual contestation cannot be merely grafted from one to the other, for reasons suggested below, among others.

3.1 Inter-American System

The American Convention on Human Rights does not contain a right to health. The right to health was set out in the Additional Protocol to the American Convention on Human Rights on Economic, Social and Cultural Rights (Protocol of San Salvador), which, adopted on 17 November 1988, notably also includes a right to a healthy environment.[64] Until 2018, the right to health was interpreted in individual petitions under the Protocol of San Salvador by the Inter-American Court as part of an overlapping nexus of rights. However, in 2018, in the case of *Poblete Vilches v Chile*,[65] the Court enforced the right to health autonomously, and has subsequently done so in at least one other case as of this writing. The Inter-American Court of Human Rights had long however noted issues such as the conditions of indigenous persons, psychiatric patients and children in prisons as violating standards under relevant law. Further, issues of informed consent, including involuntary sterilizations, had been brought to the Inter-American Commission as early as 1998 (*Mamerita Mestanza v Peru*[66]), and had been decided by the Inter-American Court in *IV v Bolivia* (2016).[67] Similarly, cases of people living with HIV/AIDS had been addressed as a matter of the right to life and non-discrimination.[68]

At least three contextual factors have contributed to shaping the jurisprudence and interpretation of these norms: (1) Latin America is a highly unequal and fragmented region,

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[63] WHO (n 59).
[64] Protocol of San Salvador, A-52 Article 10, 11.
[65] *Poblete Vilches y Otros v Chile*, IACHR, Case 12.695, Report No. 1/16 (2018).
[66] *Mestanza Chavez v Peru*, IACHR, Case 12.191, Report No. 66/00 (2000).
[67] *I.V. v Bolivia*, IACHR, Case 12.644, Report No. 72/14 (2016).
[68] *Gonzales Lluy et al. v Ecuador*, IACHR, Case N/A, Report No. 89/09 (2015).

along class, gender and ethnic/racial lines – indigenous groups and other minorities face an extreme degree of exclusion that is often reflected in health; (2) the region is dominated by conservative sects of Catholicism and, increasingly, evangelical churches, which limit SRHR being deliberated on at national level and to a certain extent in the Inter-American System (despite enormously robust advocacy in other forums on SRHR); and (3) many constitutions in the region have incorporated international human rights law, including health rights, into domestic law. In turn, the development of jurisprudence relating to health rights, as well as the use of structural mechanisms (such as the amparo and tutela) have been highly developed and have then influenced regional evolution. Finally, many other treaties (such as the Convención Belém do Pará) need to be analyzed when considering rights relevant to a specific subject under regional law.[69]

3.2 European System of Human Rights

The European Court jurisprudence has addressed significant health-related issues, often under the right to life and the right to found a family and to self-determination. The European Court uses the standard of 'margin of appreciation' as opposed to reasonableness and has accorded states significant flexibility, especially in relation to areas of health that might be considered 'ethically sensitive', such as SRHR.[70] The European Court has also been far quicker to adopt a procedural approach to contentious issues such as abortion, emphasizing the need to enforce existing laws and provide full and accurate information.[71]

Of note both for advocates and for scholars theorizing how to implement the inherently spider-web-like right to health is that the European Court of Human Rights has begun to utilize what Cali and Koch term as a 'deliberative compliance model', which also affects the kinds of creative remedies that the Court might adopt.[72] That is, the European Court does not so much dictate what actions a state should take to comply with decisions requesting structural remedies, but rather often enters into discussions with the state and maintains continuing supervision. Protocol 16 to the European Convention, called the 'dialogue protocol', will potentially encourage the explication and harmonization of the ECtHR's jurisprudence and holdings and national law.

Under the Social Charter, key right to health cases generally focus on Article 11 (the right to protection of health) and Article 17 (child rights).[73] The Committee has addressed a wide range of topics under these provisions, including: sterilization as a condition of legal gender

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[69] Organization of American States, Interamerican Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Convención de Belém do Pará) (adopted 9 June 1994).

[70] Liiri Oja and Alicia Ely Yamin '"Woman" in the European Human Rights System: How is the Reproductive Rights Jurisprudence of The European Court of Human Rights Constructing Narratives of Women's Citizenship?' (2016) 32 Columbia Journal of Gender and Law 62.

[71] *A, B and C v Ireland*, No. 25579/05 Eur. Ct. H.R. (2010); *Tysiac v Poland*, Appl. No. 5410/03, Eur. Ct. H.R. (2007).

[72] Basak Çalı and Anne Koch, 'Explaining Compliance: Lessons Learnt from Civil and Political Rights' in M. Langford, C. Rodríguez-Garavito and J. Rossi (eds), *Social Rights Judgments and the Politics of Compliance: Making it Stick* (CUP 2017).

[73] European Social Charter (adopted 3 May 1996) Council of Europe Articles 11, 17.

identity;[74] the right to a healthy environment;[75] conscientious objection by healthcare providers;[76] access to abortion services;[77] lack of sexual and reproductive health education.[78] In the *DCI v Belgium* series of cases, the Committee has addressed the exclusion of minor children who are non-nationals.[79]

3.3 African System of Human Rights

The African [Banjul] Charter on Human and Peoples' Rights (Banjul Chater), adopted on 27 June 1981, contains both civil and political rights and ESCR, including health. Article 16 states: 'Every individual shall have the right to enjoy the best attainable state of physical and mental health.' In paragraph 2, it continues: 'states parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.'[80] As the right to health is sometimes thought to be only applicable in high-income settings, it is important to note that in *Purohit and Moore v The Gambia*, the African Commission found that The Gambia fell short of satisfying the requirements of Articles 16 and 18(4) of the Banjul Charter, noting the connection between the right to health and other fundamental rights and freedoms.[81] The Commission considered the obligation of states parties 'to take concrete and targeted steps, while taking full advantage of their available resources, to ensure that the right to health is fully realized in all its aspects without discrimination of any kind' and urged the government to repeal and replace the discriminatory legislative regime, as well as to provide adequate care for persons suffering from mental health problems.

Advocates of SRHR should be aware of the extraordinarily progressive Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which sets out an expansive right of access to abortion in a regional context in which national laws remain generally restrictive (with some exceptions).[82]

Just as with the United Nations TMBs, regional systems also have both interpretative guidance on the scope of rights and how to evaluate performance, which should be consulted. In the

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[74] *Transgender Europe and ILGA-Europe v the Czech Republic*, Complaint No. 117/2015 (2018). European Committee of Social Rights.

[75] *Marangopoulos Foundation for Human Rights (MFHR) v Greece*, Complaint No. 30/2005, European Committee of Social Rights (2007).

[76] *Federation of Catholic Families in Europe (FAFCE) v Sweden*, Complaint No. 99/2013, European Committee of Social Rights (2015).

[77] *International Planned Parenthood Federation – European Network (IPPF EN) v Italy*, Complaint No. 87/2012, European Committee of Social Rights (2014).

[78] *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia*, Complaint No. 45/2007, European Committee of Social Rights (2009).

[79] *Defence for Children International (DCI) v Belgium*, Complaint No. 69/2011, European Committee of Social Rights (2013); Claire Lougarre, 'The Protection of Sexual and Reproductive Health in European Human Rights Law: Perspectives from the Council of Europe' (2018) 14 Contemporary Issues in Law 1; Claire Lougarre, 'Using the Right to Health and to Promote Universal Health Coverage: A Better Tool for Protecting Non-nationals' Access to Affordable Health Care?' (2016) 18 Health and Human Rights 35.

[80] Banjul Charter Article 16.

[81] *Purohit and Moore v The Gambia*, Communication No. 241/2001, African Commission on Human and Peoples' Rights (2003).

[82] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) (adopted 28 March 2003) African Union Article 14.

Inter-American System, indicators for the progressive realization of ESCR, including health, under the Protocol of San Salvador have been developed, as noted above. Often, arguing for a broader policy or structural reform requires not just a narrative of the case but statistical information to assist the decision-making body in offering an assessment of a given problem, and in turn whether it could be considered systemic.

4. OTHER REGIMES IN INTERNATIONAL LAW; TRANSBOUNDARY EFFECTS

Given that health is affected by so many social and political variables, it is not surprising that other legal regimes – not just at national level, but also at international level – should be considered in advocacy and scholarship. Public international law and constitutional law no longer have rigid lines separating them, and it is imperative to connect health to the institutional and legal regimes that affect its realization in both academic scholarship and advocacy.

Space precludes detailed consideration of the many regimes that affect health and intersect with human rights. Nonetheless, it is worth mentioning that, as mentioned above in the context of the Philip Morris decision, investment and trade disputes often affect health. These are often settled at specialized tribunals but Juan Pablo Bohoslavsky, the UN Independent Expert on the Effects of Foreign Debt and other Related International Financial Obligations, has noted the inappropriateness of subjecting sovereign debt disputes to technical tribunals when such issues affect the rights of people, in particular across the global South.

Intellectual property regimes, such as the Trade-Related Aspects of Intellectual Property (TRIPs) Agreement, determine questions of access to medicines as well as control over agricultural practices and inputs (such as genetically modified seeds).[83] The World Trade Organization has a mandate to enforce agreements such as TRIPs against governments. Successful litigation has been carried out in South Africa, India, Kenya and many other countries regarding accessibility of generic medications, parallel importation and compulsory licensing, anti-competitive practices and price gauging.[84] Nonetheless, piecemeal approaches to intellectual property regimes can result in uneven effects within countries (across medications and conditions) and across contexts.

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[83] Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) (adopted 15 April 1994) World Trade Organization Article 27 para 3; The TRIPS Agreement and pharmaceuticals. Report of an ASEAN Workshop on the TRIPS Agreement and its impact on pharmaceuticals. Jakarta, 2–4 May 2000.

[84] Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Access to Medicines' (1 May 2013) A/HRC/23/42; Allan Maleche and Emma Day, 'Right to Health Encompasses Right to Access Essential Generic Medicines: Challenging the 2008 Anti-counterfeit Act in Kenya' (2014) 16 Health and Human Rights 96; Lisa Forman and Jillian Kohler, *Access to Medicines as a Human Rights: Implications for Pharmaceutical Industry Responsibility* (University of Toronto Press 2012).

Additionally, a plethora of environmental treaties are directly and indirectly related to health and often have specific provisions that relate to human health.[85] [86] [87] [88] It is imperative to strategically connect the dots between environmental degradation, planetary health and health rights. Even when we are careful to define the contours of health versus interdependent and related rights, health cannot be isolated from these other issues, because to do so is to revert to a narrow biomedical framework.

Further, environmental damage done by extractive industries illustrates that in considering health rights and the intersecting regimes of trade, environmental law and the like, it is increasingly apparent that advocates need to focus on Extra Territorial Obligations (ETOs). The traditional liberal state and the understanding of state responsibilities have been progressively expanded both by ESCR (including health) and by efforts to bridge the porous public and private spheres, including through SRHR. With ETOs, a wealthy and powerful state would be responsible not just for international assistance and cooperation. It would also be responsible for some transboundary effects of its direct and indirect actions or failure to regulate.[89]

ETOs were defined in the non-binding but influential Maastricht Guidelines on ESC Rights as

> obligations relating to the acts and omissions of a State, within or beyond its territory, that have effects on the enjoyment of human rights outside of that State's territory; and obligations of a global character that are set out in the Charter of the United Nations and human rights instruments.[90]

A state has such ETOs in situations 'over which it exercises authority or effective control'; in which its 'acts or omissions bring about foreseeable effects' on the enjoyment of ESC rights, whether within or outside its territory; and in which 'the State, acting separately or jointly, whether through its executive, legislative or judicial branches, is in a position to exercise decisive influence or to take measures to realize' ESCR. Thus, for example, if a mining company is headquartered in Canada but operates in Peru, where its pollution causes health effects, Canada would be required to exercise oversight over that transnational corporation to provide regulations and effective remedial action in the event of cognizable harms to health. Efforts to expand ETOs in order to promote such accountability are nascent, but are developing rapidly in international as well as national forums.

5. CONCLUSIONS

This chapter has offered a snapshot of important sources and interpretations of international law relating to health rights. The fault lines in advocacy currently vary significantly across

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[85] Paris Agreement (adopted 12 December 2015) United Nations Framework Convention on Climate Change.

[86] Kyoto Protocol (adopted 11 December 1997) United Nations Framework Convention on Climate Change.

[87] Minamata Convention on Mercury (adopted 10 October 2013).

[88] Stockholm Convention on Persistent Organic Pollutants (adopted 22 May 2001).

[89] HRC, 'Legally Binding Instrument to Regulate, in International Human Rights Law, the Activities of Transnational Corporations and other Business Enterprises' (7 July 2018).

[90] International Commission of Jurists (ICJ), 'Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (26 January 1997).

contexts and fields, and include: SRHR, mental health, issues around environmental degradation and health effects; the effects of private debt in health (including detention in facilities); and violence. However, this chapter has emphasized that the boundaries of the right to health are in continual flux due to evolving demographic and epidemiological trends, as well as biomedical innovation and cultural understandings of what is required for health.

First, the instability inherent in the norms makes it more readily apparent that arguments regarding the interpretation of any aspect of the right to health must be carefully justified based on normative and empirical grounds. As is evident across these various legal regimes and regions, different premises will produce different interpretations of health-related rights, some of which are contextually dependent, such as in relation to the design of health systems. In making a claim for a right to health, advocates are implicitly arguing that there is some societal responsibility for patterns of (ill)health involved in the specific facts of a case or situation. In the course of that argument, they will need to combat views that construct health: (1) as a matter of individual biology or behavior, isolated from social context; or (2) even if socially determined, as a matter of personal morality or political agendas as opposed to a legal matter.

Second, it is essential to remember that health is closely related to broader social policy; therefore narrow foci on biomedical treatments may produce entitlements for a patient or group of patients but are unlikely to change the underlying drivers of patterns of (ill)health. Third, health systems should be understood as social institutions, governed by fundamental constitutional commitments to equality and dignity. Just as we need to understand a justice system to realize the right to due process, it is not possible to realize the right to health without considering the institutional forms under which it is addressed in a given society. Finally, many of the determinants of health we have discussed, ranging from environmental damage to the marketing of commercial products to pharmaceutical policies, arise in transnational space. Thus, it is increasingly essential to engage and hold accountable the donor states that, through bilateral action and multilateral institutions, make decisions that ultimately affect people's health, including through calling for greater regulation of ETOs by states in the global North.