THE RIGHT TO HEALTH UNDER INTERNATIONAL LAW:

A PRELIMINARY STUDY

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TENZIN JANGCHUP KHAMPA

CENTER FOR INTERNATIONAL LEGAL STUDIES

SCHOOL OF INTERNATIONAL STUDIES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI

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CENTRE FOR INTERNATIONAL LEGAL STUDIES
SCHOOL OF INTERNATIONAL STUDIES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110 067 (INDIA)

Tel. : 26704338
Fax : 91-011-26717580
Gram : JAYENU

Date: 27/07/2012

DECLARATION

I declare that the dissertation entitled **"THE RIGHT TO HEALTH UNDER INTERNATIONAL LAW: A PRELIMINARY STUDY"** submitted by me for the award of the degree of **MASTER OF PHILOSOPHY** of Jawaharlal Nehru University is my original work. This dissertation has not been previously published or submitted for any other degree of this University or any other university.

Khampa

TENZIN JANGCHUP KHAMPA

CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

B. S. Chimni

PROF. B. S. CHIMNI
(CHAIRPERSON)

DR. V. G. HEGDE
(SUPERVISOR)

Dedicated to

My Dear Grandparents- Mr. Sher Singh Khampa and Late Mrs. Shanti Khampa

&

My Loving Parents- Mr. Anand Singh Khampa and Mrs. Palden Sangmo Khampa

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ABBRIVATIONS

DG	Director General
GA	General Assembly
GS	General Secretary
HA	Health Assembly
MDGs	Millennium Developmental Goals
OAS	The Organisation of the American States
OAU	The Organisation of African Unity
SG	Secretary General
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organisation
WHO/GPA	World Health Organisation Global Programme on AIDS

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CHAPTER-I
INTRODUCTION

'Disease' has become a threat to human life as it causes enormous suffering and pain. The varying nature and impact of disease has challenged human existence time and again. According to World Health Organisation (WHO), 8.8 million new TB cases have been reported in 2010, where 1.4 million died from TB, including 0.35 million people with HIV and 5.7 million new and relapse TB cases came up[1]. According to the World Malaria Report 2010, there were 225 million cases of malaria and an estimated 781,000 deaths in 2009.[2] According to WHO Cholera, there are an estimated 3-5 million cholera cases and 100,000-120,000 deaths every day.[3] The United Nations AIDS Programme (UNAIDS) estimated that there has been a 27% increase of people living with HIV (+) as compare with 26.2 million in 1999 and 33.3 million at the end of 2009, 2.6 million people were newly infected with HIV(+), including 2.5 million children were infected with HIV(+) and 1.8 million died because of the disease.[4] The above statistics reflects the intensity of diseases which humanity is facing today.

The right to health is an established and a fundamental principle under international human rights law. According to World Health Declaration the right to health is a fundamental right of every human being.[5] To affirm the existence of right the World Health Day is observed on every year.[6] Moreover, the right to health has been acknowledged and incorporated in significant number of international and regional human rights instruments. These instruments confer on individuals some health-related human right vis-a-vis the State or international community.

[1]Also see WHO (2012) Global Health Observatory (GHO)- How many TB Cases are there ? Situation 2010.
[2] See, WHO (2010) World Malaria report 2010.
[3] See, WHO (2011) Cholera, Fact Sheet No. 107, Geneva: World Health Organisation.
[4] See, UNAIDS (2010) Report- Fact Sheet "the global AIDS epidemic: UNAIDS' Vision: Zero new HIV infections, Zero Discrimination, Zero AIDS- related death".
[5] See, WHA (1998) World Health Assembly Health for all policy for the twenty first century Agenda item 19 World Health Declaration 16 May 1998 Fifty- first WHA51.7.
[6]The World Health Day is celebrated by the WHO on 7th April of as a founding day of its organisation and each year on this day WHO selects a concern theme to work, and that theme highlights priority health areas.

Accordingly, States have the responsibility to respect, protect and fulfill these rights (Erk Christian 2011: 9).

1.1. Background

The idea of right to health, as it exists today originated a century ago with the advent of industrial revolution. Earlier societies had little or no defence against various kinds of diseases. Those who acquired the disease to which there was no cure were simply separated or segregated. For example: The two outbreaks of plague known as Plague of Justinian[7] of 542 AD and Black Death[8] of the 14th century marked the entry of quarantine measures (Basch 1999: 22). Plague was not only the disease of the middle age[9] but among them was also the diseases like Leprosy, Bubonic Plague, Smallpox, Diphtheria[10], Measles, Influenza, Ergotism[11], Tuberculosis, Scabies, Erysipelas[12], Anthrax[13], Trachoma[14], the Sweating sickness, and the Dancing mania (George Rosen. 1993: 35- 40).

Health and keeping away disease was an important concept in ancient India. Several treaties have been written on health- related issues and also treatment to be accorded to patients. The Indian idea of medicinal system draws back during the 5000 B.C. This period was associated with mythological figures, sages and seers. Dhanvantari, the Hindu God of medicine is said to have been born as a result of the

[7] The Plague of Justinian which killed many from Asia to Ireland was considered as toxic shock syndrome and not bubonic plague.

[8] The black death is also known as the Bubonic plague which is consider as the most destructive epidemic (a widespread outbreak of an infectious disease, where many people are infected at the same time) of the history of mankind.

[9] Middle- Age means the period from 500 to 1500 A.D or 05th - 15th Century, it is also known as medieval period.

[10] Diphtheria is an acute contagious infection which caused by the bacterium Corynebacterium-diphtheriae; it is marked by the formation of a false membrane in the throat and other air passages causing difficulty in breathing.

[11]Ergotism means poisoning by ingestion of ergot-infected grain products; it is characterised by thirst and diarrhoea and nausea and cramping and vomiting and abnormal cardiac rhythms; in severe cases it can cause seizures and gangrene of the limbs.

[12] Erysipelas means an acute streptococcal infection characterised by deep-red inflammation of the skin and mucous membranes.

[13]Anthrax is a highly infectious animal disease (especially of cattle and sheep); it can be transmitted to people; a disease of humans that is not communicable; caused by infection with Bacillus anthracis followed by septicemia.

[14] Trachoma is a chronic contagious viral disease marked by inflammation of the conjunctiva (a transparent lubricating mucous membrane that covers the eyeball and the under surface of the eyelid) and cornea of the eye and the formation of scar tissue.

churning of the oceans during 'tug of war' between gods and demons, gradually the medical knowledge in the Atharvaveda (one of the four Vedas)[15] which developed as the science of Ayurveda. The true Indian Medicinal system originated and developed as Ayurveda[16] and Siddha[17] systems. These systems differ very little both in theory and in practice. The significance provided in Ayurveda is the 'tridosha theory of disease'.[18] In ancient time there use to be free trade of thoughts and experiences between the Hindu, Arab, Persian, Greek and Jewish scholars. About 800 AD the Samitas of Charaka[19] and Susruta[20] were translated into Persian and Arabic. The laws of Manu in ancient India also carried the code of personal hygiene. Moreover, the archaeological excavations at Mohenjo-daro and Harrapa in the Indus Valley have as well uncovered the advanced knowledge of sanitation, water supply and engineering (Park: 2005:1-2). The colonial domination changed and transformed all these Indian systems.

The concept of 'health standards' emerged in the European context. Industrial revolution, movement of large population to cities and other related issues raised several health issues in Europe. The outbreak of contagion diseases during the middle age, hospitals were established in Europe but they only took care of the sick. In London[21], religious institutions came up as St. Bartholomew's (St. Barts) in 1123 and St. Thomas in 1215. Subsequently, secular hospitals were established as a concept of cleanliness, and followed entire Europe in 13th Century. The urban centres of

[15]The Vedas (from the Sanskrit word for "knowledge") are the most ancient sacred writings of Hinduism written in early Sanskrit; It is traditionally believed to comprise the Samhitas, the Brahmanas, the Aranyakas, and the Upanishads. The Four Vedas are: (i) Rig; (ii) Sama; (iii) Yajur; and (iv) Atharva.

[16] Ayurveda by definition implies the "knowledge of life" or the knowledge by which life may be prolonged. Ayurveda is practiced throughout India. In ancient India, The Ayurvedic medicinal authorities were Atreya (the first Indian physician and teacher in the ancient university of Takshashila about 800 BC); Charaka (Charaka in 200 AD was court physician to the Buddisht king Kaniska); Susrutta ("the father of Indian Surgery", between 800- 400 AD he compiled the surgery knowledge); and Vaghbhatt. The Ayurveda knowledge declined during the Mughal period (1526 to 1757) and subsequent years due to lack of State support (Park 2005: 1-2).

[17] Siddha system is practiced in the Tamil- speaking areas of South India.

[18] The doshas or humaors are: vata (wind); pitta (gall); and kapha (muscus). Disease was explained as a disturbance in the equilibrium of the three humors; when these were in perfect balance and harmony, a person is said to be healthy (this theory is of four humors is similar to Greek medicine).

[19] The Samita of Charaka is based on the teachings of Atreya. Charaka compiled his famous treaties on medicine as the "Charaka Samhita" Charaka mentions some 500 drugs in the compilation.

[20] "Susruta Samhita" is compilation of surgical knowledge of his time. The Susruta Samitha also includes medicine, pathology, anatomy, midwifery, ophthalmology, hygine and besides manners.

[21]The first hospital recorded in England was built in 937 A.D. in York (Basch 1999: 23).

European cities has started following the thousand years old tradition of cleaning street, disposing of dead animals and controlling of stream pollutions. In result the public awareness and hygienic standards with legislations came up and the literature has made the bathing famous (Basch: 1999: 23).

The period of industrial revolution during 1750- 1830 brought the health consciousness with the humanitarian sentiments of social conscience and economic order creating legislation in England to control abuses and occupational diseases[22] against factory workers through the Health and Morals of Apprentices Act of 1802 (Basch 1999: 32-34).

The birth of public health concept has started in England around 1840, making the State responsible for its people through the first Public Health Act of 1848 based on the Chadwick's report on sanitary awaking in which filth was considered as man's worst enemy. In 1850 in America Lemeul Shattuck also published a report like Chadwick on the health conditions of Massachusetts and following this France, Spain, Australia, Germany, Italy, Belgium and the Scandinavian countries developed their public health system. While public health concept made rapid progress in western world still the developing counties were slow in its development (for example: India was facing those main health problems, which were faced by the western world 100 years ago). Subsequently, the demand of clean water in England came up, when Thames (River) was constantly being used as both depository and drinking water, so in order to control man's physical environment a new Health Act of 1875 was brought in. The first medical officer Sir John Simon of London built a public health system in England and paved a way towards other countries to follow such administration (Park.K:2005:5).

In 1883 Germany led the first compulsory sickness insurance and so did other countries.[23] The first concept of health centres was debated in 1920 by Lord Dawson

[22] Occupational diseases and accidents were common, which are aroused from unrestricted use of lead, mercury, phosphorous, and other toxic substances in industrial process and even in household "cottage industries".

[23] England in 1911, France in 1928 and so on other countries.

in England and in 1931 the League of Nations Health Organisation[24] was called for the establishment of health centres (Park.K:2005:8). In 1943 the United Nations Relief and Rehabilitation Administration (UNRRA) was established to organise recovery from the effects of second world war, to care for the health of the millions of the displaced persons, to restore and help services and to recreate the system of international exchange for the information on the epidemic disease, in preventing the spread of typhus, assistance to malaria control in Greece and Italy and other diseases.[25] A great reason to the public health movement in developing countries was provided in 1946 by the establishment of World Health Organisation (WHO) for preventing the spread of diseases or providing the right to health. Consequently, in 1946 the Great Britain had nationalised its health service. Russia socialised medicine[26] completely and gave its citizen constitutional right to all health service (Park 2005: 9).

All these developments relations to health as a right within Europe and other developed countries did not take into account the concerns of their colonies. While colonies were exploited for natural and other resources by the European power, they did not deem it fit to provide them certain basic health facilities. Large populations perished both in Asia and Africa on account of over exploitation of natural and minerals resources. Those who worked in these plantations and mines had no proper medical or health facilities. The right to health as a legal norm did not exist for them.

However, with the decolonisation process during post Second World War and with the emergence of hundreds of new States, many new developmental issues came into prominence. Health was also one of them. The establishment of the World Health Organisation (WHO) in 1946 could be regarded as an important development in the evolution of the concept of 'right to health'. However, it took another three decades for States to shape the right to health concept into a practical workable reality.

[24] The WHO incorporated the Office International d'Hygiene Publique and the League of Nations Health Organisation in 1946

[25] See for more details on UNRRA, Lisa Haushofer, (2010: 993-1003) and Dhaar, G. M. and I Robbani (2008:78).

[26] It is a provision of medical service and professional education provided by the State to the people at government expense

Thereafter, in 1977 for first time the improvement of health as a greater social justice was brought by the World Health Assembly (WHA) Geneva. The main aim of the 30th WHA was to provide social and economical and productive life to all individuals, which is well known as the health for all by the year 2000 (HFA 2000) (H.S. Dillon and Lois. Philip (1994: 1-2). In 1978 WHO and UNICEF collectively convened an International Conference on Health and Human Rights as the Alma- Ata Declaration[27] in Kazakhstan (the USSR). It was first time, in this conference where the issue of widespread inequalities in health and health services was discussed.[28] The 1988 Riga meeting (Latvia Republic, USSR) which was held on the tenth anniversary year of the Alma- Ata, brought all the experts to examine the evidence and express their views having two sets of material beginning from the Alma- Ata and the health for all by the year 2000 and beyond. This helped in shaping the debate and decision of the 41st World Health Assembly[29] (Kumar: 2007:10-12).

The WHO brought together experts in Human Rights, international law and public health, representatives of the Office of the United Nations High Commissioner for Human Rights (OHCHR) and other UN bodies in 1997, first time during the preparation of the background paper on *"The Right to Highest Attainable Standard of Physical and Mental Health"* on rights and humanity for its informal consultation on health and human rights[30]. The outcome of the meeting conversed into 'World Health Declaration' and adopted by the 51st World Health Assembly[31] in its 10th plenary meeting in 1998 (Kumar 2007: 10-14).

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[27]The Declaration strongly affirmed that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector(Art-1). Also see the Appendix- 1 on the Declaration of Alma Ata 1978.

[28]Also see World Health Organisation (1998) From Alma- Ata to the year 2000: reflection at the Midpoint. WHO, Geneva, at P. 3.

[29]The 41st Assembly was marked by six major events: (i). the election of a new Director-General (Dr. Hiroshi Nakajima from Japan); (ii). the 40th anniversary of WHO;(iii) the 10th anniversary of Alma-Ata declaration; (iv). WHO commitments to global eradication of poliomyelitis (polio) by the year 2000; (v) consensus on a strategy for the rational use of medicinal drugs; and (vi) the Technical Discussions on "leadership development for health for all". Also see World Health Organisation (1998) From Alma- Ata to the year 2000: reflection at the Midpoint. WHO, Geneva, at P. 13.

[30]First meeting was held on 13-14 December 1999, this involved four main objectives: i). to review human rights approach with health; ii). to discuss the implication for WHO as human rights approach; iii). To discuss the complementarily between public health and human rights approach; and iv). to contribute to the development of WHO working paper on Health and Human Rights.

[31] Also see Appendix- 2.

1.2. Development of the Right to Health Concept

The right to health was first articulated in the 1946 Constitution of the World Health Organisation (WHO), whose preamble defines health[32] as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states 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." The 1948 Universal Declaration of Human Rights (UDHR) also mentioned health as part of the right to an adequate standard of living (Article. 25).

Similarly in the 1966 the International Covenant on Economic, Social and Cultural Rights, recognised "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article.12). It is important to note that the Covenant has given equal consideration to both mental health, and physical health. Since then, other international human rights treaties have recognised or referred to the right to health or to elements of it, such as the right to medical care. Subsequently, international and regional human rights instruments address the right to health in various ways. Some are of general application while others address the human rights of specific groups, such as women or children.

Right to health is recognised under various international conventions such as the 1965 International Convention on the Elimination of All Forms of Racial Discrimination (Article. 5 (e) (iv)), the 1966 International Covenant on Economic, Social and Cultural Rights (Article. 12), the 1979 Convention on the Elimination of All Forms of Discrimination against Women (Articles. 11 (1) (f), 12 and 14 (2) (b)), the 1989 Convention on the Rights of the Child (Article. 24), the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of

[32] The word "health" has been derived from the old English word "hoelth", which means a state of being sound, and was generally used to refer as soundness of the body (Michael L. Dolfman 1973: 491-497).

Their Families (Articles. 28, 43 (e) and 45 (c)).The 2006 Convention on the Rights of Persons with Disabilities (Article. 25[33]).

The World Health Assembly on 21st May 2003 adopted WHO Framework Convention on Tobacco Control (WHO FCTC). It is the first international treaty negotiated by WHO which entered into force on 27 February 2005. It has since become one of the most rapidly and widely embraced treaties in United Nations history. Setting up a secretariat and annual meetings in conferences of States Parties, has opted for the avenue of a legally binding instrument rather than mere statements of policies and strategies to achieve its aims. The WHO thus is beginning to elaborate the possibilities of the legal approach alongside the well-tried policy approach. The most recent one the World Conference on Social Determinants of Health was held in Rio de Janeiro, Brazil from 19 to 21 October 2011. India has also signed Framework Convention on Tobacco Control on 10th September 2003, and ratified it on 5 February2004.

The International Health Regulations (2005) (IHR) have entered into force on June 15th of 2007. These regulations are mandatory under international law. The purpose of IHR is "to prevent, protect against, control and provide a public health response to the international spread of diseases in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and Trade"(Art.1). These regulations are not only limited to specific diseases but also applicable to other health risks. Total 194 countries have agreed to implement these regulations through amending their domestic laws.

1.3 Scope and Objectives of the Study

Though, international law recognises right to health as a legal norm, still there is no clarity on what exactly the right to health means due to the varying approaches

[33] Article 25 (i) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his 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 control.
(ii) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

adopted by different international bodies. The existing international legal and policy framework is fragmented on account of the obligation of protection of right to health lying with many international bodies and Committees dealing with it. Moreover, the right to health is denied and discriminated in various forms by the state(s) and society on the basis of social, economic, race, place, gender and disease. Therefore, there are many complexities in realising this right in particular in, identifying of issues and protection. The scope of the present study would mainly focus on three issues i.e. the definition of right to health, compilation and survey of international and regional conventions on right to health and finally, to analyse the States practice and judicial approach to the right to health.

In view of the above background the proposed study will have the following objectives:

- To understand the definition of right to health.
- To survey the International Conventions that especially deals with right to health.
- To identify regional laws and practices with regard to right to health.
- To study the elements of discrimination by the state(s) and society in implementation of right to health.
- To examine as to whether right to health has attained the Status of customary norm under international law.

1.4 RESEARCH QUESTIONS

- What is the legal framework for the protection of right to health under international law?
- What are the elements that constitute right to health under international law so that claim based on such right has meaning?
- What is the implementation mechanism for the enforcement of right to health under international law?

- What is the status of ‘Right to health’ as an international legal norm?

1.5 HYPOTHESES

- Right rather than need based approach is required for the effective realisation of right to health as human right under international law.
- The existing international legal regime for the protection of right to health is inadequate and suffers from adhocism.
- The mechanism for implementation of right to health at international and regional level needs to be strengthened for making them meaningful.

1.6 Research Methodology

The proposed study would mainly depend on primary and secondary source materials at international and national level. The study will examine as source materials of United Nations Conventions, Resolutions, Guidelines reports of World Health Organisation, and all other international organisations related to right to health. Secondary sources include books, articles from academic journals and relevant website materials.

1.7 Chapterisation

Chapter I: Introduction

This chapter attempt to look at the background and evolution of the concept of the right to health as an international legal norm.

Chapter II: A Survey of International Legal Instrument

This chapter will attempt to provide an overview of the International legal framework on the right health through international and regional conventions, and also attempt to look definitional aspects of the right to health.

Chapter III: Implementation of the Right to Health under International Law

This chapter would analyse the international mechanisms to monitor the implementation of the Covenants and Conventions, concerning the concept of right to health.

Chapter IV: The Right to Health: Emerging Jurisprudence under International Law

This chapter will study the emerging jurisprudence on the right to health through the case laws of international courts, institutions and human rights committees' including regional human rights courts. The special focus would be place to find out the various forms of discrimination by laws and practice of the state(s) and the society on the basis of socio, economic, race, place, sex and disease. This chapter will also briefly examine Indian position on the right to health.

Chapter V: Conclusion

The last chapter will sum up the research findings and recommend with suitable suggestions for better implementation of right to health under international law.

CHAPTER- II

Survey of International Legal Instruments on Right to Health

2.1 Introduction

This chapter will explore international legal documents and principles. It also examines the issues on health and different approaches on right to health by different international bodies. The definition of right to health is more complex and at times ambiguous. The study will focus on as to how the right to health evolved as a legal or non-derogable right under international law. For the aforesaid purpose, this work is divided into four parts; the first part would focus on the origin of health as a right under international law. The second part focuses on international laws which relates with right to health. The third part, will examine the right to health laid down by the regional instruments and the final part will through the light on the UN specialised organs and its practice in this regard.

The right to health has developed from different stages of rights globally with the help of safety and preventive measures adopted by different countries. In 1403 the first security measure for health safety was established, by creating maritime quarantine[1] station or lazaretto[2] on Santa Maria di Nazareth Island (Venice). This establishment of quarantine method of confinement restricted the entering of vessels for 40 days in the mainland or jurisdiction of those countries. Due to this method even the individuals who were suffering from infectious disease or unknown illness in the crew during the journey in the Ship, were also restricted from entering the mainland, because it was believed that plague got introduced by ships and this was the reason for restricting the individuals/ vessels from entering the mainland or jurisdiction of those countries. Later, such arrangement encouraged other countries or ports[3] to follow such preventive and restrictive measures as safety purposes or security reason for their people (Basch 1999: 22-23). In achieving developmental scope of the right to health, the base of health development seems to be ruthless like the quarantine

[1] The word quarantine comes from the Italian word quarantena, meaning detention for forty-day period.
[2] Lazaretto is a hhospital for persons with infectious diseases especially leprosy as perhaps it was the first "quarantinable" disease.
[3] Genoa, Marsellies and other major ports (Basch 1999: 22).

measures as a security perspective in the beginning and started progressing in different developmental phases.

2.1.1 Origin of the Concept

The origin of right to health came as a primitive medicinal development. In India after Ayurveda, the other indigenous system of medicine namely Unani-Tibb and Homeopathy, was introduced during 10th Century by the Muslim rulers, the Unani[4] system[5] of medicine got enhanced until the British advent India during the 18th Century. Homeopathy of Germany[6] gained foothold during 1810 and 1839, based on pharmaco- dynamics of drugs.[7] In 2700 BC, China brought the world's first organised body of medical knowledge as: (i) Yang[8]; and (ii) Yin[9], the balancing of these two opposing force meant good health. Hygiene, dietetics, hydro-therapy, drugs were all used by the Chinese physicians. The first immunisation started in China, especially for prevention of smallpox. In Egypt Ebers papyrus of 1150 BC found with a mummy on the banks of river Nile, recorded some 800 prescription based on some 700 drugs. They planned cities, public baths and underground drainage. They also had some knowledge of inoculation against smallpox. Egyptian medicine later was replaced by the Greek medicine.[10]

The Code of Hammurabi in Mesopotamia during 2000 BC by the king Hammurabi of Babylon laid laws relating to medical practice, including fees payable to physicians for satisfactory services and penalties for harmful therapy. The Greek medicine period was from 460-136 BC provided the first scientific clinical case histories of 72-Volumes known as 'Corpus Hippocraticum' encompassing all branches of medicine. Hippocrates was a Greek physician in 460-370 BC often known as father of medicine, who first traced the differences between the endemic

[4] The Arabs translated the Graeco-Roman (Greeks and Roman) medical literature into Arabic, and developed their own system of medicine known as the Unai system of medicine.
[5] In 13th Century, the Unani system of medicine was firmly entrenched in cities and towns of Delhi, Aligarh, Lucknow and Hyderabad (Park 2005: 2).
[6] Samuel Hahnemann (1755-1843) from Germany propounded Homeopathy.
[7] Treatment of disease by the use of small amount of drug that, in healthy person produces symptoms similar to those of the disease being treated.
[8] Yang is believed to be an active masculine principle.
[9] The yin is a feminine principle.
[10] See Park 2005: 1-2.

and epidemic disease. His book 'Airs, water and places' is considered as treaties on social medicines and hygiene. This concept of Hippocratic stressed the relationship between man and his environment. Rome borrowed their medical knowledge through Greeks, and developed public health through baths, sewers, and aqueducts. Gelen a medicinal teacher in Rome during 130-205 AD observed that disease is due to three factors: (i) predisposing; (ii) exciting and environment; and (iii) a true modern idea.[11] The Arabs medicine contributed in the field of pharmacology, In 980-1037 Avicenna[12] compiled 21-volume of encyclopedia, 'The Canon of Medicine'.[13] The Arabs also developed pharmaceutical chemistry, introducing a large number of drugs, herbal and chemical.

The concept of the Right to Health under international law, as we understand today evolved during the industrial revolution. During the period of industrial revolution 'Health Standards' evolved. At this point of time workers were exploited and were made to work for longer period. Even children were not spared. That affected the health conditions of the large sections of people. For instance, unhealthy working and living conditions lead to the establishment of the Health and Morals of Apprentices Act 1802 in England. For the first time, time frame was introduced for working children in textile industry to work for 12 hours per day. Later, considering the deteriorating health conditions of children the Factory Act of 1883 has reduced to nine hours, for 9 to 13 years old children and 13 to16 years were made to work for 12 hours on daily basis and so conceding with such arrangements (Bash: 1999: 32-34). However, the work done by Edwin Chadwick (1842:1-204) on sanitary conditions was the major finding where he surveyed 50 towns on sanitary conditions of labouring population proved that the health and mortality rate is associated with the socio, economic differences causing the reason for early death of children before turning age of 5 years.

The Public Health Act of 1848 which was the first health law enforced while recognising that state is responsible for the people and its primary function in this

[11] Gelen was literally a medicinal dictator and author of 500 treaties on medical subjects (Park 2005: 3-4).
[12] Ibn Sina who is also known as Avicenna to western world form Arab, was an intellectual prodigy (Park 2005: 4).
[13]The encyclopedia was compiled to leave a mark on the medical theory and practice.

regard to improve the sanitary condition of towns and populous places in England and Wales by placing the supply of water, sewerage, drainage, cleansing and paving under a single local body. The act was applied within England and Wales except in the city of London and some other metropolitan areas which were already under the control of sewer commissioners.

In 1849 John Snow deducted the contamination of drinking water causing cholera by his small column of publication 'on the mode of communication of cholera (John Snow, 1849: 1-32), which later in 1852 became one of the classic epidemiological reasoning upon the River Thames[14] and led to the foundation in modern health practice. In 1882-1956 Ottoman Empire[15] also set up a quarantine station in the Red Sea in order to prevent spread of disease from Haj[16] travelers. These continuing quarantine measures and reports led to the improvement of public health as a step in realisation for the right to health (Basch 1999: 36).

2.1.2 Developments during Nineteenth Century and Beyond

According to K. Park (2005:7-8) there are four distinct stages in the development of health concepts. These are briefly discussed below:

(i) Disease Control Phase (1880-1920): This phase of health constituted disease and death control measures by the sanitary legislation and sanitary reforms designed to keep a check on man's physical environment like the sewage disposal, water supply, etc. this contributed in the improvement of health procedures considering the understanding of the right to health in a normative form.

(ii) Health Promotional Phase (1920-1960): In this phase it was realised that the individuals were being neglected in health, vis-à-vis the State has direct responsibility for individuals. Moreover, the disease control activity consequently added health

[14] See, Paul. F. Basch, 1999: 36.
[15] A Turkish sultanate of southwestern Asia and northeastern Africa and southeastern Europe; created by the Ottoman Turks in the 13th century and lasted until the end of World War I; although initially small it expanded until it superseded the Byzantine Empire (A continuation of the Roman Empire in the Middle East after its division in 395).
[16] Haj is considered to the fifth pillar of Islam is a pilgrimage to Mecca during the month of Dhu al-Hijja; at least once in a lifetime a Muslim (religion) is expected to make a religious journey to Mecca and the Kaaba.

promotion for individuals with personal health services as conducive for establishment of health centers plying with basic health services as well as eventually bringing the Community Development Programme in villages which worked through entire community with its inventiveness but it's functioning did not endure for long time, still this development seeks to shape the right to health in more better standards then just as preventive or safety measures.

(iii) The Social Engineering Phase (1960-1980): This phase saw several severe health related problems which were tried to be controlled by preventive and experienced measures but the arising out of new form of chronic disease like cancer, cardiovascular diseases, diabetes, drug addiction and alcoholism etc. It became hard to combat despite following isolation, immunisation and disinfection approaches yet the incorporation of community health services reoriented preventive and rehabilitation aspects in all sort of risk factors extending from social and behavioural relation constructing the growth of the right to health perspective for all individuals.

(iv) Health for All Phase (1981-2000): This stage seemed to observe the deviations in access to health care among rich and poor countries as well as individuals as unitedly more than half of the population was not able to access the right to health and thereupon by the initiative of the WHO members and conceptualisation of Alma-Ata Declaration[17] formulated the 34th World Health Assembly global strategy of 1981 resulting in objective 'the health for all by the year 2000'.

Later, in addition to this goal during September 2000 United Nations Millennium Development Goals (UNMDG) entered as setting the standards or determining a course of action constituting commitments targeted to be reached by the year 2015 as a socio, economic, productive life for the realisation of right to health and developmental perspective by the representation of 189 countries in New York.

2.1.3 Dimensions of Health

The right to health has many dimensions and areas of health. Health is generally achieved through a combination of physical, mental, emotional and social-well being.

[17] See Appendix- 1.

According WHO constitution[18] there are three main types of health as the physical, mental and social but many more dimensions may be added like spiritual, emotional, vocational and political. So far, all the health dimensions interlink with each other.

(a) Physical Health

The physical health is the balanced state of mind with the perfect functioning of body. This form of health has more to do with the physical functioning of the health where every organ is functioning to its optimum capacity and some of the agents for its developments are alcohol awareness, nutrition, sexual health, tobacco use and other related areas.

(b) Mental Health

According WHO mental health refers to broad array of activities directly or indirectly related to the mental well being and not just absence of mental disorder. Mental health carries major and minor illness such as Schizophrenia,[19] Manic Depressive Psychosis,[20] Paranoia,[21] Neurosis or psychoneurosis,[22] personality and character disorder.[23] According to one view (Lance Gable and Lawrence O. Gostin (2009)) persons with mental disability face obstructions through three main stereo type of assumption that they cannot make decisions, they are dangerous and only deinstitutionalise help them better.

Though, the Convention on Disability came into force, the progress seems to be minimal when compare to the right to mental health which evolved in the draft of 1946 WHO constitution stating that the health meant "a complete state of physical, mental and social well being and not merely the absence of disease or infirmity" as the mental health just does not means to exclude from society or send away in the

[18]See, WHO Constitution para 2.
[19] Schizophrenia means split personality in which a person lives in his/her dream world.
[20] Manic Depressive Psychosis is an illness in which an individual expresses extreme excitement to a depth of depression.
[21] Paranoia means when extreme suspicion occurs in a form of hallucination.
[22] Neurosis or psychoneurosis means when an individual is not in the state to react or show emotions due to fear, compulsion and obsession.
[23] personality and character disorder occur due to psychological disorder or the incidence which recalls to the unfortunate happening.

rehabilitation centers but it also means to take care through communities mental health system and multiple conditions through which he/she can be healthy.

(c) Social Health

Social well being means to harmony and integration within the individual, between each individual and other members of society and between individuals and the world in which they live. It has been as the quantity and quality of an individual's interpersonal ties and the extent of involvement with community. Social health is rooted in "positive material environment" and "positive human environment" which is concerned with the social relationship of the individual (Park.2005:12). The best example can be based on the spiritual foundation or way of life in the African Society through being with other or "Ubantu"[24] which states through the relationship with others is the recognition of individual humanity (A. E. Sadoh 2006: 136).

2.1.4 Determinants of health

Health is multifactorial. The factors, which influence health, lie both within the individual and externally in the society in which he or she lives (Park 2005: 17). In order to understand the determinants of health the Commission on Social Determinants of Health[25] published a final report in August 2008 and made three overreaching recommendations: (i) Improve daily living conditions; (ii) Tackle the inequitable distribution of power, money, and resources; and (iii) Measure and understand the problem and assess the impact of action. In 2011, the Rio Declaration confirmed the State parties of WHO to take action on the commitments addressing the social determinants of health.[26] The health determinants[27] are:

[24] Under the South African Gazette, 1996 ubantu is officially recognised as Umuntu ngumuntu ngabantu which means people are people through other people.

[25] The Commission on Social Determinants of Health (CSDH) was established in 2005 by WHO, to address the social factors leading to ill- health and inequalities and provide advice on how to reduce them. See, CSDH (2008) Closing the gap in a generation: health equity through action on the social determinants of health, final Report of the Commission on Social Determinants of Health. And also see Ilona Kickbush and Kevin Buckett (2010) "Implementing Health in All Policies Adelaide 2010". Government on South Australia and the WHO. Department of Health.

[26] The Member State took commitment for five areas of action on the social determinants: (i) Adopt improved governance for health and development; (ii) Promote participation in policy- making and implementation; (iii) Further reorient the health sector towards promoting health inequities; (iv)

(a) Biological

Biological Determinants of health refers to the genetic factors, which are 'inborn' factors that influence the health determination. Human Genetics is one of the predominant reasons in determining health challenges. Nowadays, medical genetics with new developments in medical field have provided longer and better life through advancement of medical prevention and treatment for healthier life. These progresses in medical field are only adequate when they are applied with ethical manner (Kumar 2007: 27). The Universal Declaration on the Human Genome and Human Rights[28] legally prohibits discrimination on the basis of individual's genetic characteristics and emphasis on human dignity and freedom to research only when it is necessary for progress on the basis of the principles set in the declaration.

The Convention for the Protection of Human Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997)[29] by the Council of Europe also prohibited discrimination against the person on the basis of his/ her genetic heritage and only authorises predictive genetic tests for genetic diseases. On 5th July 1996 when the cloning[30] of female domestic sheep dolly was done by the Scottish Scientist at Roslin Institute to advance the research, the whole world concern rose on the implications of cloning procedure for human reproduction and this concern concluded in forming Draft International Convention on the prohibition of all forms of Human Cloning 2004.[31] Further, the General Assembly with 84 Votes adopted United Nations

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Strengthen global governance and collaboration; and (v) Monitor progress and increase accountability. See, WHO (2011) Rio Political Declaration on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011.

[27]See, Park, 2005:19 and Kumar, 2007: 24- 40

[28] The Universal Declaration on the Human Genome and Human Rights (1997) was adopted by the General Conference of UNESCO at its 29th Session on 11th November 1997. And see, UNESCO (2000) "The Universal Declaration on the Human Genome and Human Rights: from theory to practice".

[29] It is the first international legal instrument signed by 22 Member States out of 40 of the Council of Europe on 4th April 1997. See, Convention for the Protection of Human Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997). Council of Europe. Oviedo, 4.IV.1997. Reprinted in 36 ILM 821. Aso see Marks 2004: 285-290.

[30] A general term for the research activity that creates a copy of some biological entity (a gene, organism or cell).

[31] See, Draft International Convention on the Prohibition of All Forms of Human Cloning 2004. UN. Doc. A/58/73 of 17th April 2003.

Declaration on Human Cloning through its 82nd Meeting of Fifty- ninth General Assembly.[32]

(b) Behavioural and Socio- Cultural Conditions

Behaviour determinants means when the association between health and lifestyle of individual, reflects the cultural, social and behavioural character. Many current day health problems especially in the developed countries (e.g. coronary heart disease, obesity, lung cancer, drug addiction) are associated with changes. In developing such as India where traditional lifestyles still persist, risks of illness and death are connected with lack of sanitation, personal hygiene, poor nutrition, elementary human habits, custom and cultural pattern (Park 2005: 18). The WHO's World Health Report 1995 states on the findings related to the lifestyle that 70-80% of the deaths relate to lifestyle in developing countries and 40% in developed world.[33] It is also expected that the lifestyle related diseases will worsen the conditions in developing countries due to unhealthy dietary and behavioural changes, as the Lifestyle-related behaviours are targeted together with metabolic and physiological risk factors, including high blood pressure, raised serum cholesterol, and impaired glucose metabolism.[34]

Besides, risk factors, there are also many factors in lifestyle that can actually promote health. Such as, adequate nutrition, sufficient physical activity and enough sleep etc. So in this regard, WHO adopted six priority areas for international action, they are: (i) to improve humanity's ability to prevent, treat, rehabilitate and improve training health profession; (ii) To apply cost-effective method for disease detection and management including improving screening, taking account of the generic diversity of individuals; (iii) encourage sustainable global healthy lifestyle campaign on development of children and adolescent in relation to risk factors such as diet, exercise and smoking; (iv) Sustainable financing through public health policies and legislation on pricing and taxation, in support of disease prevention programme; (v) Acceleration towards research of new drugs and vaccines, and into the genetic

[32] See, United Nations Declaration on Human Cloning 2005, Fifty- Ninth General Assembly Planetary 82nd Meeting (AM). Press Release: GA/10333. 8/3/2005.
[33] See, the World Health Report 1995: Bridging the Gaps. Geneva: WHO 1995: 12.
[34] See,WHO (2011) WHO Global Status Report on non-communicable diseases 2010: v.

determinants of chronic diseases; and (vi) Alleviation on those painful, suffering reduction and provisions for palliative care for those who cannot be cured.[35]

(c) Environmental

Environmental determinant is generally defined as the external influence or condition that affects the life and the development of an organism. It consists of those things to which man is exposed after conception. It is defined as 'all that which is external to the individual human- host'. The environment component can be physical, biological and psychological. These components are so inter-related to each other that it can through one component affect the health of the population or can favour the health environment of the individual. According to Park, some epidemiologists have used the term 'microenvironment' (or domestic environment) to personal environment which includes the individual's way of living and lifestyle e.g: eating habits, use of drugs, other personal habits (e.g. smoking or drinking) etc (Park 2005:18).

In poor countries the domestic environment remains a major factor, linked with lack of access to safe water supplies and adequate basic sanitation, upon which control of many infectious diseases largely depend, as well as, if the environment is favourable to individual then he/ she can make proper use of the capabilities. In industrialised countries, there is considerable concern on the adverse effect of the environment degradation: notably, pollution, the uncontrolled dumping of chemical wastes, and the transport and storage of potentially dangerous substances, especially nuclear wastes (Kumar 2007: 30). The ozone depletion is another threat to healthy environment, as the predicted result leads to global climate changes and these climatic conditions also affects public health, where the increasing transmission of infectious diseases through the extension of breeding areas of mosquitoes and other insect vectors of disease. The WHO and UNEP together analysed climate changes and its possible effects on human health. They have together through WHO, studied about the impact on depletion of the ozone layer on health.[36]

[35] See, the World Health Report 1997: Conquering Suffering, Enriching Humanity. Genava: WHO 1997: 136.
[36] The World Health Report 1996: Fighting Diseases, Fostering Development Geneva: WHO: 6.

The Earth Summit held on 3rd- 14th June 1992 contributed in the approach of sustainable development and environmental planning, by adopting the principles of Rio Declaration and Agenda 21 (U.N., 1993), as a direction towards sustainable development, the world leaders stressed on developments that meet the requirements of the people needs, health, well being, lives and the environment in which they depend.[37] The definition of Sustainable Development was brought by the Brundtland Commission[38] as 'development that meets the needs of the present without compromising the ability of future generations to meet their own needs'. The aiming of elimination of environment hazards depends on the legislation and the policies adopted by the States and regional authorities at the international level, the requirement of proper balancing on the environment and public health protection is needed.

(d) Health Services

The term health and family services cover a wide range of spectrum of personal and community services for treatment of disease, prevention of illness and promotion of health. The purpose of health services is to improve the health status of the population. The new pattern of diseases; escalating environmental degradation; changing economical status of social structure; the demographic evolution; the increasing developments in health technology; and growing expectations of the health care consumers, deals with health challenges. The health services to be effective must reach the social margin, impartially making the individuals access the facilities at the affordable cost of the country and community. The health service in fact does not provide good health. But, at least the most expected form of health service is good care. No matter how technically elegant or cost effective the health service is the epidemiological perspective for health services is the improvement of health (Park 2005: 19).

[37]See, UN Conference on Environment and Development 1992. (The Earth Summit), 3-14 June 1992, Rio de Janeiro.

[38] The Brundtland Commission was the World Commission on Environment and development headed by Norwegian Prime- Minister Gro Harlem Brundtland. See, the Report on the worlds Commission on Environment and Development: Our Common Future, full report. Transmitted to the General Assembly as an Annex to document A/42/427- "Development and International Co- operation: Environment".

There is a requirement for legal framework to support primary health care. The starting point of such a legal framework is to support primary health care and recognise the access to essential health care as human rights. The legislation can support primary health care through the implementation of the content of primary health care programmes and the developmental approach. The eight essential elements of health care are: health education; food and nutrition; water and sanitation; water and sanitation; maternal and child care and family planning; immunisation; prevention and control of locally endemic diseases; treatment of diseases and injuries; and the provision of essential drugs. Modern health care only function better when patient and physicians understand each other properly. So far, awareness of patients rights is evolving rapidly (Kumar 2007: 32-33).

(e) Socio- Economic Conditions

Socio- economic conditions depending on the sustainable development of a State influences the human health. A large body of evidence supports the view that the lower the socio- economic status, the higher the prevalence of disease. For the majority of the world's people, health status determined primarily by their level of socio economic development, e.g. per capita GNP, education, nutrition, employment, housing, the political system of the country etc. In many developing and developed countries, the numbers of poor people have substantially increased. Poverty is the most single determinant of health, leading to major challenges for present time (Park 2005: 18 and Kumar 2007: 33-34).

Often, the main obstacle for implementation of health technology is not technical but the country's political system. Decision concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services. The percentage of GDP spend on health is also a quantitative indicator of political commitment. To achieve the goal of 'Health For All', WHO has set out the target of 5% expenditure of each country's GNP on health care. Political commitment and leadership is needed which is oriented towards social development, and not merely

economic development. If poor health patterns are to be changed, then changes must be made in the entire socio- political system in any given community. Social, economic and political action is required to eliminate health hazards in people's working and living environment (Park 2005: 19 and Kumar 2007: 34- 35).

(f) Aging of Population

A regular increase in life expectancy, ensuring an increasingly larger population of elderly people of 65 years and over, has created in industrialised countries a new and most important societal phenomenon in the second half of the 20th century: the aging of the population. Since the longevity revolution is also expanding in developing countries, the increase in the number of elderly persons in the world will profound consequences for humanity and will represent a strong force affecting health and social services far into the next millennium (Genevieve Pinet. 1998: 151).

Today an estimated 540 million people in the world are aged 60 and above, having 330 million of old people living in developing countries. By the year 2020, the world will have more than one billion people aged 60 and over and more of than two third of them will be living in developing countries, since many of those countries will then be far advanced in the demographic transition to an aging society (Park 2005: 19 and Kumar 2007: 35).

Although the elderly in many countries enjoy better health, still for rapid aging population a major concern is the increased prevalence of chronic diseases and disabilities, both being conditions that tend to accompany the aging population where there exists a definite concentration of chronic health care problems. The long term consequences of chronic diseases are said to affect 7-10% of the world's population.[39] WHO's World Health Report 1997 stated that in 1996 the chronic diseases caused more than 24 million deaths yearly.[40] So far, the chronic disease has been regarded as problem of industrialised world but the chronic diseases have entered in the developing countries as an alarming rate (Kumar 2007: 35- 36).

[39] See, Pinet 1998: 152.
[40] See, The World Health Report 1997: 1.

(g) Gender

A gender perspective leads to better understanding of the factors that influence the health of women and men. It is not only concerned with the biological differences between men and women, or with women's reproductive role, but acknowledges the effects of the socially, culturally and behaviorally determined relationships, roles and responsibilities of men and women, especially on individual, family and community health (Pinet 1998: 160).

WHO has estimated that in different countries unsafe abortion can cause 25 to 50% of maternal deaths simply because women do not have access to family planning services they want and need or have no access to safe procedures or to humane treatment for the complication of abortion and because of costly contraceptive methods, lack of information and restrictive legislation. In a study carried out together by WHO and UNICEF, about 99% of the pregnant- related deaths occur in developing countries (55%in Asia and 40% in Africa) and by contrast.[41] The concept of gender was first used in the 1970's to describe the characteristics of men and women which are socially constructed in contrast to those which are biologically determined.[42]

The rise of the AIDS epidemic has brought to our attention, the risk of sexually transmitted diseases and vulnerability of women to HIV infection and AIDS, in all parts of the world, related to their status in society, including social and cultural expectations about their sexuality. Aging is another major issue. In most regions of the world, the elderly women does not receive particular attention from the health services and since she has less access to economic resources than men, many elderly women, especially when living alone, are subjected to conditions of extreme poverty. Education has been emphasised as a principal means of improving woman's health status and that of her children and family; lack of education acts as a major contributory factor to the feminization of poverty (Pinet 1998: 161).

[41]See, World Health Report 1996: 13.
[42] See, The World Health Report 1997: 83.

(h) Other Factors

The witnessing of the transition from post industrial age to information age has witnessed in information and communication that the development these technologies offers tremendous opportunities in providing an easy and instant access to medical information once difficult to retrieve. It contributes in sharing of information worldwide. Contributing and serving the needs of many physicians, health professional, biomedical scientists and mess media and the public.[43]

Other contribution is the health related systems (e.g. food and agriculture; education; industry; social welfare; rural development) as well adoption of policies in the economic and social fields that would assist in raising the standards of living. This includes employment opportunities, increased wages, prepaid medical programmes and family support systems (Park 2005: 19).

2.1.5 Levels of Regulatory Framework

The international law obligates states to ratify the international human rights instrument which are signed by them and domestic laws gives effect to these human rights obligation making it primary responsibility of States in insuring the right to health for all individuals. As such Paul Hunt and Gunilla Backman (Paul Hunt 2007:09; Hunt & Backman 2008: 82, 84) have also attempted to define it by summarising all legal instruments as:

"The right to health can be realised as a right to an effective and integrated health system, encompassing health care[44] which is responsive to national and local priorities[45] and accessible to all".[46]

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[43] See, Park 2005: 19.

[44] The health system should encompass in two ways: i. the health care and ii. the underlying determinants of health, such as adequate sanitation, safe drinking water, safe food, adequate nutrition, adequate housing healthy occupational and healthy environment condition, health education (sexual or reproductive health). As In 2002, diarrhoea attributable to these three factors caused approximately 2.7 per cent of deaths (1.5 million) worldwide. And also see. Fewtrell, Lorna. (2007), "Water, sanitation and hygiene: Quantifying the health impact at national and local levels in countries with incomplete water supply and sanitation coverage", Environmental Burden of Disease Series, No. 15 (Geneva, 2007). World Health Organisation.

[45] It must be responsive to both i. national and ii. local priorities. Properly trained community health workers such as village health teams known their communities' health priorities. Also, inclusive

While observing these conditions it examines that the issues of health related human rights can only be heard in three levels:

(a) National or Domestic Level

The National or Domestic Level in health rights means those States' Courts who follow their own Nations' Constitution in dealing with domestic remedies, depending on the influence of the issue causing damage on the fundamental health right of an individual. These remedies of justice are provided through the States own judicial system or special commission set by the State. In this level an individual can himself take a case.

For example: In India, the Indian Constitution through its Directive Principles provides the protection on Health. Article 39(e) of the Indian Constitution[47] directs the State to protect the health and strength of workers and tender age of children and to ensure that they are not forced by economic necessity to enter a vocation unsuited to their age or strength. Article 47 of the Indian Constitution[48] provides for the raising of the level of nutrition and improvement of public health[49]. The scope of the right to health in India when taken through the purview of Article 21[50] brought by the Supreme Court (SC), provides the right to life and personal liberty. The concept of liberty comprehended many rights, related directly or indirectly to life or liberty of a person.[51] Further, Article 48A and 51A(g), through 42nd Amendment laid down the

participation can help to ensure that the health system is responsive to the particular health needs of women, children, adolescents, the elderly and other disadvantaged groups. Inclusive, informed and active community participation is a vital element of the right to health.

[46] It must be accessible to all not only to the wealthy, but also those living in poverty; not just majority ethical group but minorities and indigenous peoples, too; not just those living in urban areas, but also remote villagers; not just men, but also women. The health system should be accessible to all disadvantaged individuals and communities.

[47] See, Article 39(e) of the Indian Constitution 1947.

[48] See, Article 47 of the Indian Constitution 1947.

[49] It also states that the State should regard the raising level of Nutrition and the standard of living of its people and the improvement of public health as amongst the primary duties and in particular, the State shall endeavour to bring about prohibition of the consumption, except for medical purposes, of intoxicating drinks and of drugs, which are injurious to health. (the right to health under the directive principles are only directives to the State and no person can claim for the non-fulfillment of these rights). Also see Kumar 2007: 170.

[50] See Article 21 of the Indian Constitution 1947.

[51] See Kumar 2007: 170-171.

foundation for improvement of environmental hygiene. Thus, the right to health along with numerous other civil, political, social and economic rights is afforded protection under the Indian Constitution. (Kumar 2007:172-173).

(b) Regional Level

The Regional Level or regional arrangements means an area embracing the territories of a group of States with common rule of law (H.O. Agarwal 2006:174-175). The regional Level remedies or justice based on health rights can be heard in the African region, the America region and the Europe level and all these regional levels have formalised judicial system with human rights organisations. However, Asian region does not contain such a treaty mechanism (Sofia Gruskin and Daniel Tarantola 2005: 9). In this level the case should first be heard at domestic level and then when the justice is not achieved brought to regional level in order to provide a human rights justice on health.

(c) International Level

The post Second World War has seen the evolution and developments of various international human rights instruments. The Universal Declaration on Human Rights (UDHR) 1948 is the starting point. After that several international instruments have been concluded refereeing to various aspects of human rights. It should be noted that some of these instruments outline provisions relating to right to health.

It should be noted that there are several regional and sector-specific instruments that also deal with issues relating to right to health. It should be noted that States are parties to some of these instruments, having an obligation to implement the provisions relating to right to health. All these international instruments do not create binding obligations. Some of them could be regulated as framework treaties that allow the states to decide their mode of implementation. In the following discussion an attempt has been made to outline and examine some of these regional and international instruments.

2.2 Right to Health and International Conventions

The International and regional human rights instruments formulating or governing the conduct of states, organisations and individuals provide individuals some sort of health-related human right vis-a-vis the state or international community has the responsibility to respect, protect and fulfill all these obligations for the betterment and welfare of its people.

The International Human Rights Conventions have dealt the right to health partially, in the light of right to life. The following section has compiled the provisions of right to health under various international human rights conventions.

2.2.1 Universal Declaration of Human Rights (UDHR) 1948

The United Nations UDHR (1948) in its Article 25(1) and (2)[52] has provides that:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his 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 control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

2.2.2 International Covenant on Civil and Political Rights (ICCPR) 1966

The ICCPR[53] in its Article 6 mentions that:

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

2. In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes in accordance with the law in force at

[52] Also see. UDHR Article 25(1) and (2).

[53] The ICCPR came in force on March 23, 1976 by resolution 2200A (XXI). The Covenant on Civil and Political Rights was adopted by 106 to 0 votes.

the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgement rendered by a competent court.

3. When deprivation of life constitutes the crime of genocide, it is understood that nothing in this article shall authorize any State Party to the present Covenant to derogate in any way from any obligation assumed under the provisions of the Convention on the Prevention and Punishment of the Crime of Genocide.

4. Anyone sentenced to death shall have the right to seek pardon or commutation of the sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases.

5. Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women.

6. Nothing in this article shall be invoked to delay or to prevent the abolition of capital punishment by any State Party to the present Covenant.

Article 7 further mentioned that:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

2.2.3 International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966

The ICESCR[54] under the Article 12 provides a definition of the right to health as:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

[54] The Covenant came in force on January 03, 1976 in accordance with the provision of Article 27 of International covenant on Economic Social and Cultural Rights 1966. It consists of a preamble and 31 Articles which are divided in five parts. The Covenant on Economic, Social and Cultural Rights was adopted unanimously by a 105 to 00.

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

2.2.4 International Convention on the Elimination of all forms of Racial Discrimination, (ICERD) 1965

The ICERD 1965[55] in its Article 5 e (iv) [56] tries to undertake that each state party shall prohibit and eliminate every form of racial discrimination during the practice related to health, medical care, social security and services. So, when an individual seeks healthcare his/her vulnerable criteria shall not appear as discrimination based on gender biasness, economical situation for affording the availability of medicine and treatment of his/her disease or suffering.

2.2.5 The Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention or CEADW) 1979

The Women's Convention or CEADW 1979[57] in its Article 11 expresses that states parties shall take proper measures in all situations involving women and make conditions for exempting them from discrimination by ensuring parallel opportunity in every sphere of male dominance[58] as concerning it to psychological wellness, in particularly contributing through security means of women during working condition moreover trying by way of facilitating and aiding them during reproduction system.[59]

[55] International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), of 21 December 1965, entered into force 04 January 1969.
[56] See. Article 5 (iv) of the ICERD.
[57] The Convention was adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979, in accordance with Article 27(1) it entered into force on 03 September 1981. The convention consists of a preamble and 30 articles divided into 6 parts.
[58] See Article 11(1) of CEADW
[59] See Article 11(1) (f) of CEADW

Thus, endeavour with suitable standards of healthcare for family planning[60] throughout pregnancy, confinement and the post-natal period, granting them with reservations where ever necessary in health facility, further providing them with adequate nutrition during pregnancy and during witnessing lactation.[61] As well as taking in the problems faced by rural women and by the significant roles which rural women play in the economic survival of their families[62], the States Parties are under obligation take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure rural women with all health care facilities in regard to their living conditions, like housing, sanitation, electricity and water supply, transport and communications,[63] including information, counselling and services in family planning[64], with raising standard of life.[65]

2.2.6 The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) 1984

The term torture described in its Article 1[66] of the convention[67] acknowledges that when an act leads to harsh physical or mental pain or suffering, ultimately contributes in breach of the right to health, since the degrading situation expresses an individual's distress that has been imposed on him/her as a punishment for the act committed or suspected to be done by him/her, or discovered alleged by a confession of third party, or by threatening him/her or a third person in order to compel the individual to do the required work by force.

Every state party to the convention shall try to seek out defensive procedure in all the acts connected through torture procuring it in their legislative, executive, judiciary and other measures,[68] making it a criminal offence[69] and punishable with

[60] See. Article 12 (1) of CEADW
[61] See Article 12 (2) of CEADW
[62] See. Article 14(2) of CEADW
[63] See. Article 14(2) (h) of CEADW
[64] See. Article 14(2) (b) of CEADW
[65] See. Article 14(2) of CEADW
[66] See. Article 01 of CAT.
[67] The Convention bears a Preamble and 33 Articles which are divided into III parts. Adopted by G.A resolution 39/46 of 10 December 1984 and entered into force 26 June 1987, in accordance with article 27 (1)
[68] See. Article 02(1) of CAT.
[69] See. Article 04(1) of CAT.

appropriate penalties.[70] So the explicit sense of the right to health can be preserved as the mental distress or the physical injuries or wounds can lead to psychological illness and social stigmatisation keeping him/her physically or mentally distraught for his/her entire life.

2.2.7 Rights of the Child (Children's Convention, or CRC) 1989

The CRC in its Article 24 provides on the right to child:

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
> (a) To diminish infant and child mortality;
> (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of 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;
> (f) To develop preventive health care, guidance for parents and family planning education and services.
> 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
> 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present Article, In this regard, particular account shall be taken of the needs of developing countries.

[70] See. Article 04(2) of CAT.

2.2.8 The Convention on the rights of protection of the rights of Migrant Workers and Members of their families (CMW) 1990

The Article of 13(3)(b) of CMW[71] presumes that when the migrant and their families member have right to expression and the state had responsibility and duty for security and protection measures on health issues. The Conventions Articles 8(1), 39(2) explain that, during State security or nation's protection the health situation may lead to an emergency. During the health or State emergency the residing dangerous (disease affected or sick) migrants can be restricted from movement or settlement, for the prevention or protection of the society. Throughout, the situation of health emergency the right can or as a moral concern cannot be taken away from them directly or whichever is necessary according to the proper situation.

The Article 12(3) puts effort to relate it with similar view of restricting ones freedom from religious belief only if it is for the protection of public health safety. Being aware of the situations article 28 provides relief to the migrant workers and their family members as the state has the duty to provide them with immediate medical assistance during emergency to keep them well or alive irrespective of the duration of employment or stay in that particular country or state where he/she is getting treatment and these rights cannot be taken away from him/her nor from his/her family.

Articles 25(1)(a), 43(1)(e) and 45(1)(c) expressively mentioned that migrant workers and their family shall also avail the favourable facilities on health related conditions like the nationals of that states based on equality in order to grant them health safety, health schemes and healthy environment to work and these conditions are in national jurisdiction of where they are availing this facilities. At last Article 70 tries to point out that the working condition of migrant workers and their family members shall apply within the same standards of fitness and human dignity in relation to safety of health as similar to citizens of those state party experiences.

[71] Adopted by resolution no. 45/148 of 18 December 1990.

2.2.9 The Convention on the Rights of Persons with Disabilities (CRPD) 2006

The CRPD 2006[72] in its preamble para (v) expresses that the state parties to the present convention shall recognise the full enjoyment of human rights and fundamental freedom of person with disability in accessing the physical, social, economic and cultural environment to health and education by all means of information and communication.

In Article 16(4) it tries to relate the suffering of disabled person as freedom from exploitation, violence and abuse by providing them with healthy environment and dignified life, Article 25(f) reiterates, that no discrimination should be practiced in health care or health services or nutrition on the basis of disability, it further estimates in Articles 27(1)(a), 27(1)(b) that safe and healthy working conditions should not be taken away in all forms of employment of person with disability and provide with equal opportunity as well as equal remuneration for work with healthy environment to work unitedly with other employees.

Additionally, Article 25(e) also provides that the health insurance or life insurance which is permitted by domestic or national laws by fair and reasonable manner to access and afford the right to health. Primarily, Article 22(2) conveys respect for privacy in personal health and rehabilitation information in order to provide them with positive right to health.

Article 25 of CRPD provides with a definition seeking the health perspective of persons with disability as:

> "the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".

It has been presumed that the right to health for persons with disability also means grant of similar rights which other individuals are experiencing as the accessibility of free or affordable health care and programmes which includes sexual and reproductive health[73] as similar Article 25(d) demands health professionals to work qualitatively for person with disability by informed and free support.

[72] The UNGA adopted ii on 13 December 2006 and came in force on 03 May 2008
[73] See Article 25(a) of CRPD 2006.

Article 25(b) provides that the right to health gives persons with disability a sufficient assistance of identification and minimising the deterioration of health condition or controlling further advancement of disability including along with them children and old persons. Article 25(c) furnishes that these services shall be available near these communities and also in rural places consecutively making them help in obtaining the right to health care facilities. The Article 26 gives right to health a broader concept where habilitation and rehabilitation of the person with disability effectively and appropriately takes place with equal support and strength in areas of health.

2.3 Regional Conventions

This section will deal with regional conventions to find out provisions which are dealing with the right to health at regional level.

2.3.1 African Charter on Human and Peoples' Rights (ACHPR) 1981

The ACHPR 1981[74] Article 16(2) ensures that the state parties to the charter shall take the required procedures in protecting the health of their people and guarantee medical assistance when they fall sick. There is also a definitional part in ACHPR Article 16(1)

> "Every individual shall have the right to enjoy the best attainable state of physical and mental health".

This proves that in 1981 itself Africa got concern in consideration with the right to health of its people and started looking forward in providing its attainments of achievements.

2.3.2 American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988)

The additional Protocol of the American Convention in Article 10(1) defines that:

> "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well being",

[74] The ACHPR 1981 was adopted on 27 June 1981

it further extends to enumerate the measures to be taken by the states parties[75] like the health should be considered as public good with essential primary public health care, covering all the benefits available to health services being subject to state jurisdiction for example, insurance policy, projects and schemes for health facilities, etc. The state parties of the Convention are also obliged to take measures for collective immunisation, prevention and treatment against occupational, endemic and all other diseases.

2.3.3 European Social Charter (1961 as revised in 1996) (1996)

The European Social Charter[76] submits to undertake measures by defining right to health

> "with a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:
> 1. To remove as far as possible the causes of ill-health;
> 2. To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
> 3. To prevent as far as possible epidemic, endemic and other diseases."[77]

It can be observed that the right to health in European Social Charter is still a right where prevention and advisory function is followed. The health right needs more enhancements in health care and health services then just being in protective form.

2.4 UN and its Specialised Agencies

The Charter of United Nation 1947 in its Article 57 states that:

> "(1) The various specialised agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and

[75] See. Article 10(2), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador", adopted at San Salvador, 17 Nov. 1988.
[76] Adopted 18 Oct. 1961, revised in 1966.
[77] Also see the European Social Charter Article 11, "The right to the protection of health". Several articles of the Charter are also devoted to related rights. For example, Article 12, "The right to social security"; Article 13, "The right to social and medical assistance"; Article 14 "The right to benefit from social welfare services". Adopted on 27 June 1981.

> related fields, shall be brought into relationship with the United Nations in accordance with the provisions of Article 63.
> (2) Such agencies thus brought into relationship with the United Nations are hereinafter referred to as specialised agencies".

The UN specialised agencies in conduct to execute the essential requirements of the right to health tries in a assisting the realisation of its discourse by its own agenda and targets in order to help the diseased, poor, disadvantaged, vulnerable and sick people all around the world equally and efficiently.

2.4.1 International Labour Organisation (ILO) 1919

The ILO[78] in its constitution has rightly set for the principles for the protection of workers that the workers should be protected from sickness, disease and injury arising from his/her employment. The Safety and health at work of ILO states that annually 317 million accidents encounters absences from work because of occupational accidents 6,300 people die every day and more than 2.3 million deaths occur per year due to work-related diseases. In 2003 the ILO adopted a global strategy[79] to improve occupational safety and health which included the introduction of a preventive safety and health culture, the promotion and development of relevant instruments, and technical assistance.

The main function of ILO is to contribute and promote social justice, to improve living standards of workers through international action and conditions, to promote economic and social stability. It is in reality a collection of international minimum standards related to health and welfare.[80]

[78] The Treaty of Versailles founded ILO in 1919 which was installed in Geneva in close relation to League of Nation. After the foundation of United Nations it became the first specialised agency under Article 57. The ILO was renewed in 1946 and has been revised several times.
[79] See, Global Strategy on occupational Safety and health (2003), Conclusions adopted by the international Labour Conference at its 91st session.
[80] See Park 2005: 709.

2.4.2 Food and Agriculture Organisation[81] (FAO) 1943

The FAO is the first UN agency created to look after several areas of world corporation in 1960 FAO organised a movement ensuring sufficient quantity and a right proportion of food to be consumed by people, constituting it as an essential requirement for developing and maintaining a better state of health through nutrition all over the world, known as - 'a world freedom from hunger campaign (FFHC)'

Basically, it was felt that malnutrition contributes to affect health and the capacity of working people and requires resource to feed them adequately with proper right to access health facilities, by enacting food safety legislation, promoting breastfeeding, discouraging unhealthy food habits, ensuring access to basic shelter, housing and sanitation, with an adequate supply of safe and clean drinking water, by distributing nutritional information.[82] The FAO major function is to help nation raise living standards, to recover nutrition by every single individual, to increase efficiency of farming, forestry and fisheries, improving the conditions of rural people for productive work (Park 2005: 709).

2.4.3 World Health Organisation[83] (WHO) 1946

The WHO[84] constitution in its preamble stated the definition of 'the right to health' for the first time as:

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

Every year on World Health Day[85] takes new theme on the specific aspects on health for 2012 the theme is "Better Research for Better Health" this subject tries to assemble sequentially information on health policies, improving outcome of

[81] The 1943 foundation of FAO was made after second world war, when difficulties arose in getting sufficient food. The convention entered in force in 1945. In 1951 it moved its seat from Washington. DC. to Rome.
[82] See, UNHR Fact sheet No.34 "The right to adequate food".
[83] The WHO was founded in 1946 by the world health conference and came in force on 1948.
[84] The health activities and financial asset of United Nations Relief and Rehabilitation Administration (UNRRA) 1943 was taken by the Interim Commission on the WHO.
[85] 07 April, 1948 when the WHO constitution came in force it was celebrated every year as 'world health day'.

population health, so that more countries are helped by medical and health service research meeting the Millennium Development Goals (MDGs).

It has been observed that among all the UN specialised agencies the WHO is the unique in its functioning as it has its own constitution, own membership, governing-bodies and own budged. The WHO is a part of UN. WHO has been influenced by the Alma-Ata Conference (1978) on primary health care that provided both WHO and UNICEF with common charter for health, and the Global Strategy for Health for All by 2000 both UNICEF and WHO tried to strive the goal of Health for All (HFA) through primary health system and MDGs in order to meet the objectives. WHO specific responsibility on health promotion and international standards are as: the prevention and control of specific diseases,[86] development of comprehensive health services, environmental health, health statistics, bio-medical research, health literature and information, cooperation with other organisations.

2.4.4. The World Bank[87] (World Bank, IBRD) 1944

The World Bank (WB) was created with a purpose of helping less developed countries in order to raise their standard of living, by giving loans for projects that will lead to economic growth. The projects are usually concerned with electric power, roads, railways, agriculture, water supply, education, family planning, etc. Health and environments have been added to most of the projects (Park 2005: 709).

The WB through IDA in 2000-2011 provided $24 billion for health across 19 development sectors to reach MDGs (focusing on reproductive health, early childhood nutrition and HIV/AIDS) in order to help countries afford quality health care, protect from poverty illness, and to achieve universal access of health care in a fiscally sustainable way.

[86] With the international health regulation (IHR) WHO tries to eradicate and make commitments almost for all the disease through WHO activities by automatic telex reply service (ARTS), the weekly epidemiological report (WER), WHO emergency scheme for epidemics and Immunisation against common diseases of childhood (Expanded Programme on Immunisation), etc..

[87] The 1944 Bretton Woods Conference led to the result of the World Bank (WB). The World Bank and IMF works simultaneously

2.4.5 The Joint[88] United Programme on HIV/AIDS (UNAIDS)[89]

In 1989 first international consultation on AIDS and human rights was organised[90]. The UNAIDS is an innovative partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support, it moreover tries to meet its mission by uniting,[91] speaking out,[92] mobilising,[93] empowering[94] and supporting[95] further by building political action and to promoting rights of individuals to enhanced global health and development.

The target and commitments of UNAIDS in consideration with to right to health are: to reduce sexual transmission, preventing HIV among drug users, eliminating new HIV infections among children, 15 million accessing treatment, avoiding TB deaths, closing resource gap, eliminating gender inequalities, eliminating stigma and discrimination, eliminating travel restrictions, strengthening HIV integration. Twelve United Nations entities have issued a Joined statement calling for the closure of compulsory drug detention and rehabilitation centers.

2.4.6 United Nations Development Programme (UNDP) 1996

The United Nations Development Programme (UNDP) is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. The UNDP works in poverty reduction,[96] environment & energy,[97] democratic governance,[98] HIV/AIDS,[99]

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[88] UNCHR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, World Bank and WHO.

[89] The UNAIDS was established by the resolution of UN Economic and Social Council in January 1996.

[90] By the cooperation with WHO/GPA (World health Organisation Global Programme on AIDS) and the United Nations Centre for Human Rights. See Report of an international Consultation on AIDS and Human Rights, Geneva, 26 to 28 July 1989 (HR/PB/90/2).

[91] by United Nations system, civil society, national governments, the private sector, global institutions and people living with and most affected by HIV

[92] for the people most affected by HIV in defense of human dignity, human rights and gender equality;

[93] making ourselves and others accountable for results from political, technical, scientific and financial resources

[94] Agents of change with strategic information and evidence to influence and ensure that resources are targeted where they deliver the greatest impact and bring about a prevention revolution.

[95] Inclusive country leadership for sustainable responses that are integral to and integrated with national health and development efforts.

[96] In order to promote inclusive and sustainable human development and works.

[97] To establish effective partnerships, secure resources, and implement programmes to support sustainable, low-carbon, climate-resilient development pathways.

women empowerment[100] and crisis prevention & recovery.[101] In 1990, the United Nations Development Programme (UNDP) published the first Human Development Report. Alongside the report, UNDP created the Human Development Index, a summary measure of various human development indicators, such as maternal mortality, childhood education, gender disparities, poverty, etc.

The index and report represented a major progression in development theory, which aimed to "[put] people back at the center of the development process" by going beyond income to assess people's long-term wellbeing. In 2010 the first global project on public health adaptation to climate change[102] has been launched by WHO, along with UNDP through the Ministries of Health and other relevant national partners in Barbados, Bhutan, China, Fiji, Kenya, Jordan, and Uzbekistan This WHO/UNDP project will receive US$4.5 million for activities from the Global Environment Facility (GEF), Special Climate Change Fund (SCCF) as well as leverage significant co-financing and in-kind support from 2010-2014.

2.4.7 The United Nations High Commissioner for Refugees[103] (UNHCR) 1949

The UN Refugee Agency is a United Nations agency its mandate is to protect and support refugees at the request of a government or the UN itself, by assisting in their voluntary return, local mixing or resettlement to a third country. In 1947, the UN founded the International Refugee Organisation (IRO) it was the first agency to deal with all aspects related to refugee.

The universal health related problems with the refugees have always been immunisations, tuberculosis, sexually transmitted infections, HIV, Hepatitis B, lead poisoning, parasitic infections, malaria, anemia and mental health, so far in all of its activities, the refugee agency pays particular attention to the needs of children and

[98] To develop institutions and promote participation, accountability and effectiveness at all levels.
[99] To strengthen coordination of in HIV responses, promote human rights and gender equality and respond for risk populations (HIV).
[100] to ensure participate equally with men in public dialogue and decision-making and influence the decisions that will determine the future of their families and countries.
[101] in all situations of fragility, incorporate necessary elements of crisis prevention and timely recovery support.
[102] This projects aim to "increase adaptive capacity of national health system institutions, including field practitioners, to respond to climate-sensitive health risks".
[103] UNCHR was established in 14 Dec. 1950 and was founded as a subsidiary organ of the General Assembly by resolution no. 319 (IV) of December 1949.

seeks to promote the equal rights of women and girls. By reducing situations of forced displacement by encouraging states and other institutions to create conditions which are conducive, in protection of human rights and the peaceful resolution of disputes.

2.4.8 United Nations International Children's Emergency Fund[104] (UNICEF) 1946

The UNICEF in 1946 was formed to deal with rehabilitation of children by war. In 1953, it was renamed as UN children's fund it works in collaboration with WHO, and other specialised agencies. In 1987 the UNICEF brought out a landmark report on "Adjustment with human face" dealing with the negative impact of Structural Adjustment Programmes (SAPs) on health and education.

Later, this concept was taken by WHO to describe policies recommendation focusing on protecting public expenditure on the social sectors, arising from study of health and education.[105] UNICEF prime focus is on children and HIV/AIDS, basic education and gender equality, child survival and development and policy advocacy and partnership.

2.5 Summation

The Origin of the right to health developed from the medicinal antiquity. The medicinal knowledge and practice of the ancient time helped in bringing volumes of compiled literatures like: (i) the Samitas of Charaka and Susruta from India; (ii) Code of Hammurabi from Mesopotamia and (iii) Ebers Paprayans from Egypt, etc. All of the documents carried, records and knowledge of ancient period, making medicines and its practices advance for modern era. The proper channelisation of drainage-system of Mohenjo-daro and Harrapa civilisation in Indus Valley has traced ancient knowledge towards the realisation of Cleanliness and Sanitation. As admitting by the progress made for the achievements of Health development through Cleanliness and Sanitation practices, some conditions are improvement to be realised, they are:

[104] UNICEF established in 1946 to rehabilitate the children in war ravaged countries. In 1953 its name was changed to UN Children Fund but retained the initials, UNICEF.

[105] SAPs have now largely been replaced by the Poverty Reduction Strategy Paper (PRSP) process. Nowadays World Bank operational guidelines also require analysis impact of adjustment programmes on the poor.

(i) supply of water; (ii) sewage; and (iii) drainage, etc. The development brought by Chadwik and Snow etc. in understanding the drawbacks of dirt and filth made new developments, bringing Countries to realise for legislation and reform, formation on Sanitation. The Health and Morals Rights 1802 evolved the factual sense of the health rights perspective considering the conditions of workers, especially children and women. In 1920 to 1960 for first time, the State realised that it has a direct responsibility for individuals. The Post Second World War, brought evolution of UDHR in 1948 with several international instruments dealing on the issue relating to the right to health. The right to health is embedded in all major human rights conventions, but the right to health is dealt exclusively in the ICESCR 1966 Articles 12(1) and 12(2). However the Covenant of ICCPR and ICESCR including UDHR are not legally binding, under international law. Moreover, all Human Rights Treaty Monitoring bodies' observation and concluding remarks are recommendatory in nature. Thus, it fully depends on the States willingness to implement the right to life and the right to health. On the other hand the other Human rights Conventions also dealt with the right to health partially but not exclusively. It is submitted that the right to health has not emerged as a full fledged right on date. Whereas, the right to health obligation is derived from right to life and States are obliged to enforce the right to health under the guise of the right to life. Further, the Regional and UN Specialised Agencies provide the right to health a growing perspective with attainments of achievable right according to their partial arrangements. WHO is only the agency at present which provides full health related programmes and the Alma- Ata declaration of WHO, brought in new perspective of understanding rights to Health as Human Rights. But, the WHO recommendations are also non-binding in nature.

CHAPTER -III

Implementation of the Right to Health

The preceding chapter dealt with some of the aspects related to the development of the right to health through international and, regional conventions and the UN agencies. But all these developments will only have a real meaning if there are mechanisms to enforce these rights through monitoring and observations. Implementation and obligation of these rights availed. This chapter focuses on the implementation mechanism of the right to health under international law. The first part hereto tries to give an overview picture of how the monitoring system takes place under International law in order to respect, protect and fulfill the supporting connection of the right to health along with human rights perspective. The second part attempts to explore how the achievements of the right to health is monitored and executed at the regional levels by the regional conventions of Africa, America and Europe from human rights viewpoint and finally, the third part seeks perception in attaining the realisation of the right to health by the UN agencies with special concern on WHO.

3.1 Treaties Monitoring Mechanism

Provisions on right to health are segregated under various international instruments. The procedure of implementation on right to health by all the member states under every convention falls as similar with the procedures as it is associated with the identical course concerning directly with different Treaty Monitoring Committees. It is necessary to acknowledge that the ICESCR plays an important role in achieving the realisation of the right to health to in its fullest form. However, it is important to know how the Treaty Monitoring Bodies are functioning in achieving the implementation of the right to health. It is also necessary to understand how all the nine core human rights committees undertakes their monitoring functions through member States for the implementation of right to health. In the following section shall examine these issues.

3.2 International Human Rights Treaties

There are ten core human rights treaties but only nine of them monitor the implementation at international and regional levels through its Committees. Besides this procedure there is a Sub-committee on Prevention of Torture (SPT) which works according to the Optional Protocol to the Convention against Torture (OPCAT) 2002, and it is the tenth core monitoring human rights treaty which monitors the place of detention specially by visiting the sites.

3.2.1 Implementation and Monitoring of the Human Rights Committees

The implementation of the treaty is monitored by the Committees of respective Conventions. The monitoring bodies are consisting of independent experts, who monitor the provisions of human rights conventions and implementation at domestic level. These Committees will meet in different intervals and discuss on the submitted reports and functioning on its procedures following all required mandates by the composition of the treaty monitoring bodies. Furthermore, the Committees experience the situations, by articulating with the ideas of situation and observing through circumstances with proper study and analysis, and rationally functioning on the human rights including the right to health and trying to reach its realisation

3.2.2 Composition of the Committees

The implementations of the rights stated in the International Treaties are carried out by the Committees of the respective treaty bodies. These Committees monitor compliance of the rights provided in respective conventions which include the right to health. The following section will deal with the composition of treaty bodies and their function, complainant mechanism and procedure for the implementation of these Committee recommendations.

3.2.3 Human Rights Committee 1976 (HCCPR) under ICCPR (1966)

The implementation procedure under the International Covenant on Civil and Political Rights (ICCPR) 1966 and its Protocols 1989 is carried by the Human Rights Committee 1976, The Human rights Committee has 18 committee members[1] who are elected for every 4 years under Article. 32[2] of ICCPR and initially the report have to be submitted in one year and later on, the periodical reporting is submitted by every 4 years[3] and the committee holds three sessions in a year in Geneva or New York or any convenient place as the commission may determine in consultation with the Secretary- General (SG) of UN and the State parties concerned.

Article 41 provides the committee to accept the Inter-State complaint mechanism and the first protocol provides for the individual complaint mechanism which also known as "communications". The State parties concerned shall equally share the expenditure which estimated to be provided by the SG of the UN to the members of the Commission and with the help of Article. 42(9) and Article.49 (10) the SG of the UN if necessary shall be empowered to pay expenses to the members of the Commission before the reimbursement made by the concerned state parties.

[1] See Article. 28 to 39 of the ICCPR, the members of the Committee are the person of high moral character and recognised competence in the field of human rights, having equal geographical distribution, providing preference to the legal experts who serves in their own performing capacity of functions impartially and conscientiously. However, the Committee members are elected with majority of votes from the members present in the procedure.

[2] The members are nominated by the state parties (not more than two persons and nationals of the same state) and then elected by secret ballot under Article 29 ICCPR. They can be re-elected if nominated, however the term of the nine members elected at the first election shall expire at the end of two years.

[3] All reports are submitted to the Secretary-General (SG) of the United Nations containing all the factors and difficulties affecting the implementation of the present Covenant, taking all the measures adopted to give effect to the rights recognised and the progress made in the enjoyment of those rights. By Article 40(2) of the ICCPR the SG after consultation with the Committee transmits only those parts of the report to the concerned specialised agencies which they are competent of. But, under Article 40(4) when the report is studied by the Committee then only it tries to transmit the report and general comments as appropriate to the State parties and this same report submitted by the state parties along with the comments can also be submitted to the ECOSOC. At last for all these response the state parties may submit observation on all made comments by the Committee through Article 40(5).

3.2.4 Committee on Economic, Social and Cultural Rights (CESCR) 1987 under ICESCR

The Committee on Economic Social and Cultural Rights 1987 implements the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 by its monitoring mechanism. The Committee on Economic Social and Cultural Rights was established under ECOSOC Resolution 1985/17 of 28 May 1985 to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSOC) as laid in Part IV of the Covenant. There are 18 members[4] in the committee. The State parties must initially report within two years of accepting the Convention and then thereafter every five years. The Committee holds two sessions per a year, consisting of three-week plenary and a one week pre-sessional working group, meeting normally in Geneva. All the States parties are obliged to submit regular reports to the Committee on how the compliance of Covenant provisions should takes place. All the reports[5] should be submitted to the Secretary-General of the United Nations under Article 16(2) (a) transmitting ECOSOC with the copies of report for consideration in accordance with the provisions of the ICESCR 1966.

In the report, the Article. 17(2) indicated about the factors and difficulties affecting the degree of fulfillment of obligations under the present Covenant. Through Article 16(2) (b) the concern specialised agencies also transmit with copies of report by the Secretary-General of the United Nations and under Article. 20. The States Parties to the present Covenant with the concerned specialised agencies may submit comments to the Economic and Social Council on any general recommendation made under Article. 19 or provide reference to such general recommendation in any report or any documentation of the Commission on Human Rights, and at last under Article.21 of

[4] The members are of high moral character and recognised competence in the field of human rights. Members are elected for a term of four years by States parties in accordance with ECOSOC Resolution 1985/17 of 28 May 1985. Members serve in their personal capacity and may be re-elected if nominated.

[5] With regard to individual complaints, on 10 December 2008, the General Assembly unanimously adopted an Optional Protocol (GA resolution A/RES/63/117) to the International Covenant on Economic, Social and Cultural Rights which provides the Committee competence to receive and consider communications. The General Assembly took note of the adoption by the Human Rights Council by its resolution 8/2 of 18 June 2008, of the Optional Protocol. The Optional Protocol was opened for signature at a signing ceremony in 2009. In addition to the Committee on Economic, Social and Cultural rights, other committees with competence can consider individual communications involving issues related to economic, social and cultural rights in the context of its treaty.

the covenant the Economic and Social Council may submit from time to time to the General Assembly reports with recommendations of a general nature and a summary of the information received from the States Parties to the present Covenant and the specialised agencies. The Committee examines each report and addresses its concerns and recommends the measures to the State party in the form of "concluding observations". The Committee also publishes its interpretation of the provisions of the Covenant, known as general comments. However, the Article.17 gives it a relaxation of not submitting the report but provides ECOSOC to publish its own reporting.

3.2.5 Committee on the Elimination of Racial Discrimination 1969 under CERD

The implementation of the Convention on the Elimination of All Forms of Racial Discrimination 1965 is carried out by the Committee on the Elimination of Racial Discrimination 1969. The Committee has 18 members[6] who are elected for four years and out of those eighteenth, nine are elected for only two years, ensuring stability and transformation in the composition of the Committee and when acquainting the information originally the report[7] needs to be submitted just within one year after the entry into the force by the state concern and later every two years or whenever the committee request so.

The member states under the treaty body reports[8] in two parts: a common core document[9] and treaty- specific document, along with this there are three other mechanisms procedure through which the committee performs its monitoring

[6] The members are experts considered from equal geographical distribution with high moral standing and acknowledged impartiality with principal of legal system. They are elected in accordance with Article 08 of CERD which sets out the rules for the election of members of the Committee at a meeting of States parties. Members serve in their personal capacity and may be re-elected if nominated.

[7] The report is based on the legislative, judicial, administrative or other measure which has been adopted to give effect to the provision of the convention.

[8] In the report as regard to the practical implementation and the progress achieved in the Convention the actual situation should reflect.

[9] The common core document should include general information about the reporting State, the general framework for the protection and promotion of human rights, as well as general information on non-discrimination and equality and effective remedies in accordance with the harmonised guidelines (HRI/MC/2006/3 and Corr.1).

functions: the early-warning procedure,[10] the examination of inter-state complaints and the examination of individual complaints. The committee meets normally twice a year in Geneva comprising for three weeks plenary session and a one week pre-session working group. And after the meeting the committee also publishes its analysis of human rights provision as general comments or the general recommendations on its thematic issues and thematic discussions.

3.2.6 Committee on Elimination of Discrimination against Women 1982 under CEDAW

The implementation of the Convention on the Elimination of All Forms of Discrimination against Women 1979 and its protocol 1999 is carried out through the Committee on Elimination of Discrimination against Women 1979. The Committee has 23[11] independent experts to monitor the implementation of the CEDAW by the help of the submitted reports to the Committee. The report is initially submitted after one year and later every four years. Normally the meetings are held at United Nations headquarters or at any other convenient place as determined by the Committee, annually for a period of not more than two weeks. During its sessions the Committee considers each State parties report and addresses its concerns and recommendations to the State party in the form of concluding observations.

In accordance with the Optional Protocol to the Convention, the Committee is mandated to: (a) receive communications from individuals or groups of individuals submitting claims of violations of rights protected under the Convention to the Committee and (b) initiate inquiries into situations of grave or systematic violations of women's rights. These procedures are optional and are only available where the State concerned has accepted them. The States Parties submit the Reports to the SG of the United Nations, for consideration by the Committee, which they have adopted to give effect to the provisions of the present CEDAW Convention under Article 18(2), the

[10] In 1993, the Committee adopted a working paper A/48/18, Annex III deciding that the early warning measures and urgent procedures could be used to prevent serious violations of the Convention. At its 45th session in 1994, the Committee decided that preventive measures including early warning and urgent procedures should become part of its regular agenda.

[11] They are experts of high moral standing and competence in the field covered by the Convention on women rights across the world.

Reports may indicate factors and difficulties affecting the degree of fulfillment of obligations under the present Convention, under Article. 21(2) The SG of the UN transmits the reports to the Commission on the Status of Women for its information and under Article 22 the specialised agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention since it falls within the scope of their activities.

The Committee may also invite the specialised agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities. The Committee also formulates general recommendations and suggestions. General recommendations are directed to States and concern Articles or themes in the Conventions. During its annual session, the Committee members discuss these reports with the Government representatives and try explore with them the areas for further action made by the specific country. The Committee also makes general recommendations to the States parties on matters concerning the elimination of discrimination against women.

3.2.7 Committee against Torture 1987 under CAT

The implementation of the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment 1984 is carried by the Committee against Torture. The Committee has 10 members.[12] The first reporting under the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment 1984 is submitted within one year after the entry into force of the Convention by the member States and thereafter the reports shall be submitted every four years on any subsequent developments. The CAT meets in Geneva and normally holds two sessions per year consisting of a four week session in April/May and another four week session in November.

[12] The CAT consists of 10 independent experts that monitor implementation of the Convention against Torture and other Cruel, Inhuman Degrading Treatment or Punishment by its State parties. The experts are the nationals of States Parties, elected by those States through secret ballot. They are elected for a term of four years and are eligible for re-election.

The States Parties Pursuant to Article 19 of the Convention shall through the Secretary General of the UN submit to the Committee, reports on the measures taken to give effect to its undertakings under the Convention. Further reports and additional information may also be requested by the Committee. At each session, the Secretary General of the UN notifies the Committee of all cases of non-submission of the said reports. In such cases, the Committee may transmit to the State Party concerned a reminder about the submission of such report or reports.

As to the actual formulation of the report, the Committee has prepared general guidelines containing precise instructions on their form and content in order to inform fully the Committee on the situation in each State Party. For the examination of the reports by the Committee, the Committee invites representatives of the States Parties to attend the meetings only when their reports are considered. It may also inform a State Party from which it decides to seek further information that it may authorise its representative to be present at a specified meeting. Such a representative should be able to answer questions which may be put to him by the Committee and clarify, if required even those certain aspects of the reports which was already submitted by his State. After its consideration of each report the Committee in accordance with Article 19 paragraph 3 of the Convention may make such general comments on the report as it considers appropriate. It may particularly even indicate on those obligations of the State concerned under the Convention which have not been discharged.

The Committee's observations are then transmitted to the State Party which can be replied from them.[13] In addition to the reporting procedure the Convention establishes three other mechanisms through which the Committee performs its monitoring functions viz (i) individual complaints or communicatoins[14]; (ii) Inquires; (iii) Inter-State complains. The Optional Protocol to the Convention, which entered into force in June 2006, established the Sub-Committee on Prevention of Torture (SPT). Under the Optional Protocol, States parties has to establish an independent national preventive mechanism for the prevention of torture at domestic level, the SPT has empowered to

[13] By the end of its seventeenth session in November 1991 around 40 reports had been examined by the Committee.

[14] Individual's complaints are the claim made by the individuals on the violation of the rights by the State under the Convention

inspect places of detention by going there. The Committee also publishes its interpretation of the content of the provisions of the Convention, known as general comments based on the thematic issues.

3.2.8 Committee on the Right of the Child 1990 under CRC

The implementation of the Convention on the rights of the Child 1989 and its optional protocols 2000 is carried by the Committee on the Right of the Child. The CRC has 18 members, who initially submit their reports in first 2 years just after signing the treaty and then later by every 5 years. The Committee meets in Geneva and normally holds three sessions per year consisting of a three-week plenary meeting and a one-week pre-sessional working group meeting. The Committee examines and address its concerns and recommendations in the form of "concluding observations" to all the concern State Parties, The Committee even considers individual complaint, yet there has not been any complaint made.

The violation on child rights can also be raised to other committees who deal with child right directly or indirectly, the committee also reviews additional reports based on the two additional protocols[15] to the Convention. On 19 December 2011, the UN General Assembly approved a third optional protocol[16] on a Communications Procedure, which allows individual children to submit complaints regarding specific violations of their rights under the Convention and with through its first two optional protocols. In 2010, the Committee considered reports in two parallel chambers of 9 members each, "as an exceptional and temporary measure", in order to clear the backlog of reports. The Committee also publishes its interpretation of the content of human rights provisions, known as general comments on thematic issues and organises days of general discussion.

[15] The Convention works on monitoring implementation for the involvement of children in armed conflict and on sale of children, child prostitution and child pornography, etc.
[16] The third optional protocol still has to be entered into force and it will come in into force only when ratification by 10 UN Member States is done.

3.2.9 Committee on Migrant Workers (CMW) 2004 under CRMWMF

The Implementation of the Convention on the protection of the Rights of All Migrant Workers and Members of their Families 1990 is carried by the Committee on Migrant Workers. The Committee has 10 members in the Committee who meets holding two sessions in Geneva (it held its first session in March 2004). States have to report initially in one year and then later every five years. The Committee under certain circumstances (only when 10 States parties have accepted this procedure in accordance with Article 77 of the Convention) can consider individual complaints or communications from individuals claiming that their rights under the Convention have been violated. At the moment only two States have accepted this procedure. The Committee also organises general discussion on work and interpretations and publishes theme related statements from the provisions in the Convention as general comments. The Committees examines each report and addresses its concerns and recommendations to the State party in the form of "concluding observations".

3.2.10 Commission on Rights of Person with Disabilities under CRPD (2006)

The implementation of the International Convention on the persons with Disabilities 2006 is carried out by the Commission on Rights of person with Disabilities. There are 18 experts,[17] initially the report is made after two years and later on after every four years in their individual capacities rather than as government representatives. (The term of six of the first Committee members will expire after 2 years). The members of the Committee serve in their personal capacity, having high moral standing and with recognised competence and experience in the field of disability. The members of the Committee shall be elected by secret ballot from a list of persons nominated by the States Parties from among their nationals at meetings of the Conference of States Parties. The initial election shall be held no later than six months after the date of entry into force of the present Convention. Article.33 explains that

[17] Under Article 34 of the Convention the Committee was composed of twelve experts during the time of entry into force, later by the additional sixty ratifications or accessions to the Convention, the membership of the Committee increase by six more, attaining a maximum number of eighteen members. The members of the Committee shall serve in their personal capacity and shall be of high moral standing and recognised competence and experience in the field of disability.

States must set up national focal points governments in order to monitor implementation of the Convention's precepts. States must also set up some sort of independent monitoring mechanisms which usually takes the form of an independent national human rights institution. States must report initially within two years of accepting the Convention and thereafter every four years. The Committee shall meet in Geneva and normally hold two sessions per year.

3.2.11 Committee on Enforced Disappearances (CED) 2011 under International Convention on the Protection of all Persons from Enforced Disappearance 2006

The implementation of the International Convention on the Protection of all Persons from Enforced Disappearance 2006[18] is carried by the Committee on Enforced Disappearances. The Committee has 18 members and in initial period it has to report within two years after accepting the convention and later on by every States must report initially within two years of accepting the Convention. The Committee examines each report and makes suggestions and general recommendations on the report as it considers appropriate to the concerned State Party. In accordance with Article 31, a State Party may at the time of ratification[19] of this Convention or at any time afterwards declare that it recognises the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction claiming to be victims of a violation by this State Party of provisions of this Convention. The Committee holds two sessions per year and meets in Geneva.

[18] On 18th December GA by resolution 47/133 proclaimed the Declaration on the protection of All Persons form Enforced Disappearance. The Convention gets applied when Disappearances, violate various economic, social and cultural rights. Furthermore, an enforced disappearance can also particularly cause negative impact on family members. The absence of the family's main breadwinner, particularly in less affluent societies, frequently leaves the family in such dire straits that a number of the rights enumerated in the international Covenant on Economic, Social and Cultural Right cannot be realised, such as: the right to health. The family and friends of disappeared persons experience slow mental anguish not knowing whether the victim is still alive and, if so, where he or she is being held, under what conditions, and in what state of health. They may also be threatened or suffer the same fate themselves and may expose them to even greater danger (Fact Sheet No.6/Rev.3:1- 4) and Also see Articles 9(1), 17(3)(f) and 18(1)(f) in Annex 4 in the Fact Sheet No. 6/Rev.3: 40-50.

[19] On 30 March 2012, Bosnia and Herzegovina ratified the International Convention for the Protection of All Persons from Enforced Disappearance and on 16 February 2012, Costa Rica ratified the International Convention for the Protection of All Persons from Enforced Disappearance.

3.3 The Complaint Mechanism in the International Treaty Monitoring Body

The Complaint by the States for the non-compliance of the recognised rights under the international treaties can be made in three ways, these complaints can be produced or communicated by an individual or a State under the human rights treaties they are the individual complaints; inquiries; and the State to state complaints.

3.3.1 The Individual Communications or Individual Complaint

The individual communications or individual complaint can be made by an individual only when his/her rights have been violated by a State party, to that international treaty and only if that State has recognised the competence of the committee and to receive complaints under such committees. The complaint can also be made by the third parties on behalf of the individuals but only when the individual has given a written consent or if the individual is incapable of giving such consent. The individual complaint can be made by under six of the treaty bodies they are International Covenant on Civil and Political Right;[20] The International Convention on the Elimination of all forms of Racial Discrimination;[21] The Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment;[22] The Convention on the Elimination of All Forms of Discrimination against Women;[23] The Convention on Migrant Workers;[24] and the Convention on the rights of persons with disability.[25]

[20] The HRC may consider individual communications relating to States parties to the First Optional Protocol to the ICCPR.
[21]The CERD may consider individual communications relating to States parties who have made the necessary declaration under Article 14 of CERD, also see the Convention on CERD.
[22]The CAT may consider individual communications relating to States parties who have made the necessary declaration under Article 22 of CAT, also see the Convention on the CAT.
[23]The CEDAW may consider individual communications relating to States parties to the Optional Protocol to CEDAW, also see the Convention CEDAW, and also see the Convention on CEDAW.
[24]The Convention on Migrant Workers contains provisions for allowing individual communications to be considered by the CMW; these provisions will become operative when 10 states parties have made the necessary declaration under Article 77, also see the Convention CMW.
[25]The CRPD may consider individual communications relating to States parties to the Optional Protocol to the Convention on the Rights of Persons with Disabilities, also see the Convention CRPD.

3.3.2 State to State Complaints or Inter State Complaints

The State Parties can make a complaint for the violations of the rights committed by another State Party to the international treaty. The treaties under which the State to State Complaints can be made are International Covenant on Civil and Political Right;[26] the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment[27]; The Convention on Migrant Workers[28]; and The International Convention on the Elimination of all forms of Racial Discrimination[29].

3.3.3 Resolution of Inter-State Disputes Concerning Interpretation or Application of a Convention[30]

Article 29 CEDAW, Article 30 CAT and Article 92 ICRMW provide for disputes between States parties concerning interpretation or application of the Convention to be resolved in the first instance by negotiation or, failing that, by arbitration. One of the States involved may refer the dispute to the International Court of Justice if the parties fail to agree arbitration terms within six months. States parties may exclude themselves from this procedure by making a declaration at the time of ratification or accession, in which case, in accordance with the principle of reciprocity, they are barred from bringing cases against other States parties. Like the inter-state complaint procedure, this procedure has never been used.

[26] The ICCPR Articles 41-43 states on the resolution of disputes between States parties, through the establishment of an ad hoc Conciliation Commission. The procedure only applies to those State parties who have accepted the competence of the Covenant, also see the Covenant ICCPR.

[27]The Article 21 CAT permits the State Party to make complaints about those State parties who have not provided effects to the provisions of the Convention. But this procedure is only implemented when that State Party accepts the competence of the Committee, and also sees the Convention on CAT.

[28] The Article 74 of CMW provides procedure for the Committee to consider complaints from one State party which considers that another State party has not given effect to the provisions of the Convention. This procedure applies only to States parties who accept the competence of the Committee, and also see the Convention on the CMW, and also see the Convention on the CMW.

[29] The Articles 11-13 of ICERD states that the procedure for the resolution of disputes between States parties, for fulfillment of the State's obligations under the relevant Convention through the establishment of an ad hoc Conciliation Commission. This procedure normally applies to all States parties to ICERD, also see the Convention on the ICERD.

[30] Also see the Fact sheet no 30 (2010) Office of the United Nations High Commissioner for Human Rights: 37.

3.3.4 Inquiry Procedure

The Committee Against Torture[31] and the Committee on the Elimination of Discrimination Against Women,[32] can through their initiative, make an inquiry on the complaints which they have received through reliable information containing well founded indications on serious or systematic violations of the conventions in a State. The Committee can make Inquires in the State only when the country has accepted the competence of the respected Committees. The State party may also exclude the Committees Competence by making a declaration under Article 28 for CAT and under Article 10 of the optional Protocol CEDAW at the time of ratification or accession.

3.3.5 Thematic Mechanism and the Special Rapporteur

The Special Rapporteur's are appointed by the Human Rights Council to examine, advice and report back on the country situation by a specific human rights theme. The position is honorary and the expert is not a staff of the United Nations nor paid for his/her work. He/she expresses his/her view in an independent capacity and does not represent his/her Government. Since 1979, special mechanisms have been created by the Commission on Human Rights, the UN human rights body, to examine specific country situations or themes from a human rights perspective. This system of experts is better known as the Special Procedure system. In April 2002 by resolution 2002/31 the original mandate of Special Rapporteur[33] on the right to health from the Commission on Human Rights as the right to health of everyone to the enjoyment of the highest attainable standard of physical and mental health was instituted. Subsequently, the replacement of the Commission by the Human Rights Council in June 2006,[34] the mandate was approved and extended through the Human Rights Council by its resolution 6/29 of 14 December 2007.

[31] Also see Article 20 and 28 of the Convention Against Torture.
[32] Also see Article 8- 10 of the Optional Protocol to CEDAW.
[33] Paul Hunt was UN Special Rapporteur 2002-2008 on the right to health.
[34] The United Nations Commission on Human Rights, replaced by the Human Rights Council in June 2006.

3.3.6 Treaty Monitoring Bodies and Practice of the States

After understanding all the monitoring composition under the international human rights treaties it make easier to recognise how the treaty monitoring body functions in its implementing procedures. But, still the hindrance that occurs is well analysed by Riedel (2009:29), as he argues that until there is no implementation mechanism at the domestic level there will not be a clear understanding for the authenticity of reporting and monitoring system functioning in the treaty monitoring body, and further he even tries to highlight that in the past, some governments misunderstood that the economic, social and cultural rights were just limited to the progressive attainment of goals by their discretionary power to follow the promised goals set in international levels considering it as a flexible obligation. So far, the right to health is a subject to progressive realisation and availability of resources, when it is monitored and implemented by all these treaty monitoring mechanism. Generally there are two broad concept of understanding can be made out:

(a) Freedom from Discrimination; harmful traditional practices; torture; inhuman or degrading treatment and; freedom of association, assembly and movement.

(b) Rights to life; medicine; food and nutrition; shelter; education; confidentiality; participation; individual liberty and integrity; benefits through scientific progress with its appliance and; to obtain and communicate information.

3.4 Implementation of Right to Health under Various Levels

The obligation to respect, protect and fulfill the rights make it an essential requirement to be followed by the Governments absolutely not just for the violated rights but as well for realising and complying with the conditions making the obligations possible for the right to health. It has been assumed through the treaty monitoring body that the right to health requires more than just passing a law for the achievements of its commitments proceeded by the treaties because the realisation of

the right to health in Article 2(1) of the ICESCR generally understands it as a matter of progressive rights "to the maximum of its available resources" trying to achieve its goals and this progressive realisation can only be reached when international assistance and cooperation is provided regardless of their economic development towards attaining the realisation of the right to health for every individual moreover the obligation on such considerations are:

3.4.1 States Practice

The State parties have to respect the enjoyment of the right to health for all individuals from other countries. Whether, they are prisoners, refugees, minorities, asylum seekers or illegal migrants, as the Government has an immediate responsibility to provide the medical care to all even whom the government arbitrarily decides to withhold.

3.4.2 Protection of Health

The State parties have to keep a proper check on the violation of the right to health made by non-state actors and offer some sort of remedy to prevent third parties from violating the right of health and ensure that privatisation of health is not stopping availability, accessibility, affordability and quality of health with regard to the Article 12 of ICESCR. The obligation to protection also provides arrangements for health insurance or health care depending on the health conditions of the individual in order to access the health requirements during the occurrence of any inevitable violence happened to him/her. The obligation of fulfillment on the State parties gives enough recognition to the right to health in national, political and legal system preferably through its legislative, executive, budgetary, judicial implementation procedures by adopting national health policy and in fact a state may even be responsible in providing enough resources required for promoting health needs to its people.

3.4.3 The General Guidance for Sates and Reporting Procedure

The International Covenant on Economic Social and Cultural Rights[35] together with the Convention on the rights of child 1989[36] is the most comprehensive deposition of the right to health according to the Working Paper No.3 on health and human rights Andrew Clapham and Mariano Rubio (2002: 13-16) have presumed that Article 12 of ICESC not only provides for wider obligation falling on the health facilities but also realises the child rights providing maternal benefits. However, still no state has entered to the full realisation of the right of a child to the highest attainable standard of health. The Human rights treaties have provided the general idea how the compliance falls on the treaty monitoring bodies relating to all the human rights issues concerning with the health- related consequences being one of the main subject and how the government functions on the implementation of the designed programmes, policies and services on health. It has been clearly addressed in the General Comment No. 14 about the imposition of duty on the member states to take all necessary steps to ensure that every individual has access to health facilities, good services so every person can enjoy the highest attainable standard of physical and mental health. The reporting of information under the General Guidance on the right to health through Article 12 of ICESCR (Kumar 2007:144-145):

(i) Data collected on physical and mental health status of the population of the particular member State;
(ii) Percentage of GNP as well as of the national budget spend on health and the resources allocated to the primary health care;
(iii) Life expectancy and infant mortality;
(iv) National policies, laws and practices for health;
(v) The role of international assistance in the full realisation of the right enshrined in Article. 12 of the ICESCR.

[35] On 12th August 2011 there were 160 states who were party to the ICESCR. There has been no general reservation made by any state during the ratification or accession for Article 12 of ICESCR.
[36] On 12th August 201, 193 states were party to the CRC, three states Argentina, The Holy Sea and Poland have made general reservation in relation to the art 24 of the CRC which talks about family planning.

(vi) Measures adopted to improve the physical and mental health situation of vulnerable and disadvantaged groups and the effect thereof;

(vii) Measures to be adopted by the governments to the present Convention

(a) Reduce stillbirth- rates and infant mortality and provide for the healthy development of the child with advantages of breast feeding;

(b) Improve all aspects of environment and industrial hygiene with prevention of accidents;

(c) Prevent, treat and control epidemic, endemic and occupational and other diseases with provisions of adequate nutritious food and clean drinking water.

(d) Assure all medical services and medical attention in the event of sickness and even during the pre- natal and post natal services or obstetric care;

(e) Producing innovative medicine;

(f) Providing education and information on major health problems.

3.5 Implementation of Right to Health under Regional Conventions

The Regional Conventions play a major role in providing the implementation of the right to health in Domestic level in a proper way making the functioning more transparent while promoting and protecting the right to health as a fundamental human right. According to Manoj Kumar Sinha (2008: 60-61) the domestic application of right to health in ICESCR consider two main principles of international law. The first principle which Sinha tries to explain highlights the Vienna Convention on the Law of Treaties of 1969 and he states it as "to provide treaty obligations the State should modify their domestic laws".

The second obligation according to him is under Article 8 of the UDHR and General Comment No. 9 on Domestic Application of the Covenant 1999 para 3 where he attempts to states that the every individual has a right to receive an effective remedy by all the competent national tribunals for every act relating to the violation of fundamental rights which he/she has been guaranteed by the law or by the constitution of that country. As still the appropriate measure in implementing the right to health varies from one State to other (Kumar 2007:142). Therefore, in order to realise the

achievements at domestic level it is necessary to understand how the functioning of implementation procedures functions through the regional levels.

The regional Human rights mechanism for the African region is located within the Organisation of African Unity and it tries to monitor its implementation by the human rights instrument using the African Charter. The American region works with the Organisation of American States and monitors the American region based on the American Convention of Human Rights. In the European region the human rights system is formed as the Council of Europe and functions according to the European Convention on the protection of Human Rights and Fundamental Freedoms and the European Social Charter.

3.5.1 The Organisation of African Unity (OAU)

The implementation of the right to health takes place under the African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Right. The African Commission on Human and Peoples' Rights known as "The commission", functions through the Organisation of African Unity[37] (OAU) to promote human and peoples' right and ensures their protection in Africa.[38]

The African Commission on Human and Peoples' Right has eleven members elected for six years and can be re-elected,[39] the complaints are submitted to the Chairman of the Commission and can also be addressed to the Secretary General (SG) of the OAU and the State Concern. The members initially meet within three months and later at least once a year under Article 64. Under Article 62 every State Party reports within two years on the measures recognised and guaranteed under the present Charter. Under Article 59 every activity of the Commission is published by the Chairman of the Commission after the acceptance and decision made by Assembly of heads of

[37] In 1963 with 32 independent member States' the Organisation of African Union was established in Addis Abeba (Ethiopia). It has 53 members and moving from political liberalised phase to economic integration with peace and security for their socio-economic development process. The OAU adopts the mandate to achieve health, sanitation and nutritional corporation by harmonising their policies. In the field of health preventive medicines and public health measures are being applied all over Africa.
[38] See Article 30 of the African Charter on Human and Peoples Right 1981.
[39] The term for four elected office member are two years and the term of three in four years also see Article 36 of the African Charter on Human and peoples right 1981.

States and governments or can be made confidential unless wants to publish the report.

The African Court on Human and Peoples' Right is a regional Court created[40] to make judgement for African Union State' and in 2004 the African Union Assembly decided to integrate it with the African Court[41] of Justice and signed a protocol on this behalf in 2008 at the summit held in Sharm El Sheikh, Egypt. There are eleven judges[42] serving for six years and can be re-elected only once, there is a President[43] and a Vice- President elected for two years and can also be reelected once. The cases are brought in the Court under Articles 18(1)(a), 18(1)(b), 18(1)(c) and 18(1)(d) by the State- Parties, the Parliament and other Organisation authorised by the Assembly. Under Article 18(2) third party can be made by special reference. Under Article 37 decisions will be binding on the particular case to the parties and by Articles 25(1) and 35(2) the judges will provide the reasons for the judgement stating their names who took part in the decision and it is signed by the President and the Registrar. There can be a separate or dissenting opinion on the judgement by the judges through Article 36. Revision can be made only under Article 41(1) if any new fact is discovered within six months and an advisory opinion can also be taken through Article 44(1) and 44(2).

3.5.2 Monitoring Mechanism under OAU

The Monitoring of the right to health in OAU is done through the periodic reports presented by the state parties. In the African Commission on Human and Peoples' Rights individual and collective complains procedure is done under Article 16 of the African Charter on Human and Peoples' Rights and through Article 13 and 14 in the African Charter on the Rights and Welfare of the Child. Although there is a protocol

[40] The protocol to the Charter created the African Court on Human and Peoples' Rights entered into force in 2004 and was adopted in 1998.
[41] The Court seat is in Arusha, Tanzania and gave its first judgement on 15 December 2009.
[42] The term of five elected judges, by first election will expires in four years and others for full term. Also see Article 8(1), 8(2), 8(3) and 3(3) of the protocol to the African Court justice of the African Union.
[43] The president under Article 10(1), 10(2) and 10(3) of the protocol to the African Court justice of the African Union sits in the Court and Modalities for their election is set by the Rule of the Court.

to the African Charter on Human and Peoples' Rights that established the African Court on Human and Peoples' Rights which came in force on January 2004, but still at present it is not functioning full-fledged.

3.5.3 African Charter on Human Rights and Peoples Rights

(a) The realisation of the right to health to the fullest without any discrimination on vulnerability or gender.[44]
(b) Provide health protection to women and children with proper sanitation, physical health infrastructure, human resource and health structure, nutrition, quality of medicine and etc.[45]
(c) Protect from harmful traditional practices and torture.[46]

3.5.4 Obstructions and Requirements for the Implementation

The OAU has the mandate to follow all the treaty mechanism to which it is party and having obligation to these treaties OAU attempts to oblige its member states function properly but still the attachments of the right to health is negligible in true sense in some regions of OAU. The right to health in OAU is more complicated than other regional level as the country not only faces economical and social differences in every span of time but there is also a hard realisation of Health Rights in daily practices.

The African country faces more health issues which are transmitted through insects, water and food born diseases, intimate relations, and traditional practices (female-circumcision) where health education should be provided to all specially women in order to let them know the health related issues and complications. The African region not just has health problems but also deals with major ethnical and traditional or religious practices, having genocides and violence with low literacy rates,[47] African

[44] See the preamble para 8, Article 18 and 28 of African Charter on Human and Peoples' Right.
[45] See Article 18 of African Charter on Human and Peoples' Right.
[46] See the General Recommendation No. 14 (ninth session) 1990 of Committee on Elimination of Discrimination against women under Article 10 and 12 of the convention which deals on female circumcision and Article 5 of the African Charter on Human and Peoples' Right .
[47] In Africa there is Seventy five percent of illiteracy according to Samoura, Djely K. (1996:145-146).

region faces more under nutrition problem.[48] The OAU with the help of its 53 members made some of the important commitments on health, they are Abuja Declaration 24-27 April 2001 for HIV/AIDS, Tuberculosis (TB) and other related Infectious diseases. The governments by this declaration was requested to allocate at least 15%[49] of the country's annual budget to the improvement of their health sectors relating to HIV/AIDS, Tuberculosis and other Related Infectious Diseases. The commitment for making traditional medicine and traditional health practice for prevention care and management of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases was made with the scaling the role for education and information in the fight against HIV/AIDS. The Protocol relating to the Peace and Security Council of the African Union (PSC) 09th July 2002, Durban[50] has made significant impact on this agenda.

The PSC has mandate of deploying peace keeping missions to assist in cases of genocide, war crimes and crimes against humanity. Regional women's organisations have taken full advantage of this space to make the voices of women heard on issues of sexual violence and limited access to health services to ensure their right to sexual and reproductive health. The Solemn Declaration on Gender Equality in Africa (SDGEA) held in 2004 on 6-8 July, Eithopia having the Member states are required to report on an annual basis on actions progressively taken to achieve gender parity and equality. Take specific measures to women education, to ratify African Charter on Women in Africa by the end of 2004 and support public campaigns ensuring entry by 2005 as well as other instruments on gender equality by all states. The Draft Continental Policy Framework on Sexual and Reproductive Health and Rights (2005), 10-14 October, Botswana is based on the framework of achieving the Millennium Development Goals (MDGs) 2015 call for reduction of maternal and infant mortality and morbidity in Africa. The Maputo Plan of Action (MPoA) 2006 (2007-2010) 18-22 Sep, Mozambique for the operationalisation of the Continental Policy Framework for Sexual and Reproductive Rights fighting for HIV/AIDS pandemic and other infectious disease. Brazzaville Commitment (2006), 08th March Congo build

[48] Under nutrition is the major risk factor for over 28% of deaths in Africa. Some 2.9 million deaths annually. Also see Joyce, Mulama. (2004)
[49] Abuja Declaration (2001), only six countries in Africa allocated 15% of their budget.
[50] Entered on 26th December 2003.

infrastructure at all levels, providing medicines to all for and health care for STI/HIV/AIDS by 2010.

The Africa Health Strategy for the period (2007-2015) 9-13 April, Johannesburg where the AU member states and the Regional Economic Communities (RECs) are expected to use the Health Strategy as an inspirational framework within which they fulfill their roles. The Strategy proposes strengthening of health systems with the goal of reducing the disease burden through improved use of resources, systems, policies and management with equity and The African Union Gender Policy (2009), Tanzania came with the Policy takes into account the diversity in social, cultural and traditional settings in making efforts to address cultures and practices which militate against the enjoyment of freedoms and rights of women and girls.

The gender policy provides a mandate for the operationalisation of Assembly commitments by developing capacity to establish Gender Management system by 2020 and gender budgeting system till 2015 with African Women trust funds ensuring accountability from 2011 for mobilising and planning resources. It has been observed that the reproductive and gender rights with HIV/AIDS, TB and Malaria are the leading issues in African region. As the heads of the States and the Government on 02 to 04 May 2006, made a special summit on HIV/AIDS, Tuberculosis, and Malaria in Abuja, and Nigeria, adopted the Abuja Call on "Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by A United Africa in 2010". Subsequently, an arrangement on HIV/AIDS, TB and Malaria was developed to accelerate implementation in Member States. In adopting the Abuja Call, the Heads of State imposed on the African Union Commission (AUC) to report back to the Assembly and Ministers of Health for carrying review of five year progress in 2010. The expansion and adoption of these policy instruments have been guided by the visualisation, duty and Strategic Framework of the AUC for the period 2003-2007 and continues to benefit from the directives and key strategic plan for the period 2009-2012.

3.5.5 The Organisation of American States (OAS)

In the Inter-American Commission on Human Rights monitors the implementation of the right to health through the American Convention on Human Rights and the American Court on Human Rights. The State parties to the protocol of San Salvador can submit periodic reports on health through the Article 10.

The Inter-American Commission on Human Rights is a Commission with a seven members[51] elected for four year and can be reelected only once under Article 34. The State Parties under Article 42 submits the same report to the Commission that is transmitted to Inter American Economic and Social Council and the American Council for Education, Science and Culture so that the Commission is aware on the advancement of the information under charter of OAS. The Commission submits an annual report to General Secretariat (GS) of the OAS and makes recommendations and requests the member states to adopt progressive measures in human rights and supply information on the framework of domestic laws and constitutional provisions adopted by the State Parties. If the matter transmitted by the Commission is not settled then through Article 51(1), 51(2) and 51(3) with a vote of an absolute majority the Commission can decide that the State has taken adequate measures and whether to publish the report or not.

The Inter American Court of Human Rights Court consisting of seven judges and the Court appoints its own Secretary. The Commission transmits the report to the Court by making recommendations and proposals as it finds fit and the Court will only hear the case when all the last resorts are met. The Jurisdiction of Court under Article 62(3) and 64(1) states the Court shall look at all the case concerning the interpretation and the application of the provisions of the Convention or other treaties concerning the protection of human rights in the States of America and provided that all the States Parties have recognised such jurisdiction whether by the pursuant of preceding paragraphs or by a special agreement. If Court finds out that there has been a violation of a right or freedom protected by this convention then under Article 63(2) it pays fair compensation to the injured party and also provide with opinions regarding the

[51] The term of three members of the first election will expire at end of two years.

characteristics of its domestic laws with the international instruments.[52] It has been observed that under Article 66 reasons are to be provided for all the judgments and if the decision doesn't carries unanimous opinion then the dissenting or separate opinion can be attached by the judge.

The judgement of the Court is final and not subject to appeal and in case of disagreement of the judgement then within ninety days from the judgement can request for interpretation under Article 67. And where the compensatory damages occur the case has to executed in the concerned country in accordance with domestic procedures governing the judgement of the execution with concern to the domestic laws[53] and the State Parties to the case together with the Convention State parties are notified the judgement by the Court[54] and by Article 37 the court's decision will be binding on the parties and in respect to that particular case.

3.5.6 Monitoring Mechanism under OAS

The monitoring of the right to health in American Region is done through the Inter-American Declaration on the Rights and Duties of Man Article XI which establishes the right to prevention of health and to well-being and with the American convention on the Protocol of San Salvador in Article 10(1).

3.5.7 Provisions under OAS:

(a) Preservation on sanitation social measures[55] which may be related to food[56], clothing, shelter and medical care.[57]
(b) Health insurance care or access to medical service.[58]
(c) Maternal and Child health care.[59]

[52] See Article 64(2) of the American Convention on Human Rights.
[53] See Article 68 of the American Convention on Human Rights.
[54] See Article 69 of the American Convention on Human Rights.
[55] See Article 7(e) and 11 of the protocol of San Salvador.
[56] See Article 12 of the protocol of San Salvador.
[57] See Article 9 and 17 of the protocol of San Salvador.
[58] See Article 9 and 17 of the protocol of San Salvador.

(d) Extend medical care with the help of public and community resources.[60]

(e) Provide social security scheme.[61]

(f) Adequate assistance during health care and sickness.[62]

3.5.8 Obstructions and Requirements for the Implementation

The obstruction in the right to health of OAS is very different as despite spending around 16.2% on GDP in 2007[63] for health care still inadequacy and poor quality of health care appears with a wasteful expenditure on administrative and ligation costs. America[64] has more health insurance realising the right to health through progressive realisation. Still around 46.3 million people were uninsured during 2008. Discrimination prevails on regular basis with low-representation of minorities in health workforce, there is a requirement of Community base health care for proper health service. America is facing more problem of obesity.[65]

The bringing of Clinton Initiative Program in June 7-8 2012 announced that nearly 3.9. Million American through the CGI American commitment will provide more than 12,000 people with health services, the Government will try to achieve Millennium Developmental Goals (MDGs) 2015 through all the measures. The US Government funds on average $3,307 for research on Pancreatic Cancer per new cancer. The US and foreign health policy provides financial and technical resource for

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[59] See Article 9, 15, 16 and 17 of the protocol of San Salvador.
[60] See Article 10 (2) of the protocol of San Salvador.
[61] See Article 9 of the protocol of San Salvador.
[62] See Article 10 of the protocol of San Salvador.
[63] Also see The National Health Expenditure Projections 2008-2018. Forecast Summary.
[64]The US health insurance can be both private as well as public, most of them are covered by the employer in the family (under group plans, which are less then the individual policy) In such type of Insurance the premium is paid by the employer and the rest by the employee. Also see (Melik Ozden 2006: 28-29)
[65] According to WHO at least 2.8 million adults die each year as a result of being overweight or obese. Obesity is an abnormal growth of the adipose tissue due to an enlargement of fat cell size (hypertrophic obesity) or an increase in fat cell number (hyperplastic obesity) or combination of both. Obesity is often expressed in terms of Body Mass Index (BMI). A person with a BMI of 30 or more is considered obese and 25 and more is overweight. In the industrialised countries it has been suggested such increase in body weight is due to the reduction of physical activity, rather than change of food intake or by other factors. Also see Park (2005: 316). Obesity has major risk for chronic diseases like diabetes, cardiovascular and cancer. And also see fact sheet No. 311 (2012).

expanding the infrastructure on health and through research focusing with health problems to poor countries and beyond US borders.

3.5.9 The Right to Health and the Council of Europe

The European Commission on Social Rights receive complaints about the violation of the right to health and social security under Article 12 and for the social and medical assistance Article 13 and the right to benefit from social welfare service under Article 14. The Council of European Committee has fifteen members elected for six years and can be reelected only for one more year. The State Parties submit annually the report on accepted provisions of the Charter and the implementation and practice of law from the Charter taking place and the Committee decides the situation in conformity with the Charter it has been observed that when a State does not comply with the decision of the Committee believing the State does not comply with the Charter, then the Committee can ask the State to change the laws and practices according to the situation and on these situations the Committee gives concluding decision on the State performance as conclusions which is published every year.

Convention for the Protection of Human Rights and fundamental Freedoms has equal numbers of judges as equal to the high contracting parties[66]. The judges are elected by the Parliamentary Assembly with respect to each High Contracting party. The term of office shall expire when they reach the age 70 and shall hold office until replaced addition to this no judge shall be dismissed until there is majority of two-third votes.[67] The Court has a registry[68] that lays down court rules with the functions and organisation having Rapporteur's functioning during the single judge sitting formation and work under the authority of the President of the Court. The planetary court sets up a Chamber for a fixed period of time and elects its president and one or two vice president for a period of three years who may be re-elected. There is an ex-officio member of the Chamber and a Grand Chamber the elected judge with respect

[66] See Article 20 of the Convention for the Protection of Human Rights and fundamental Freedoms.
[67] See Article 23 of the Convention for the Protection of Human Rights and fundamental Freedoms.
[68] See Article 24 of the Convention for the Protection of Human Rights and fundamental Freedoms.

to the High Contracting Party concerned and if there is no judge to sit or unable to sit then the president may decide from the list submitted in advance by the party.[69]

The Grand Chamber also includes the President of the Court, the Vice- Presidents, the Presidents of the Chambers and other judges chosen in accordance with the rules of the Court and when the case is referred to the Grand Chamber under Article 43, no judge from the Chamber which rendered the judgement shall sit in the Grand Chamber, with the exception of the President of the Chamber and the Judge who sat in respect of the High Contracting Party concerned.

3.5.10 Monitoring Mechanism under the Council of Europe

The monitoring of the right to health in Council of Europe is done by the Article 3, 7 and 17, 8 and 17, 23 and 11 of the Europeans Charter.

3.5.11 Provisions on Right to Health under European Social Charter 2009

(a) The rights of pregnant women, women, children, young persons, and elderly persons.[70]

(b) Protection from health related issues of environment, alcoholism, tobacco, drugs, accidents, endemic and epidemic diseases.[71]

(d) Promote vaccination programme, food[72] and safety,[73] social security scheme.[74]

(e) Adequate assistance during health care and sickness.[75]

3.5.12 Obstructions and Requirements for Implementation

[69] See Article 26(4) of the Convention for the Protection of Human Rights and fundamental Freedoms.
[70] See Article 7, 8, 17 and 23 of European Social Charter.
[71] See Article 11 of European Social Charter covers numerous issues relating to public health.
[72] See Article 11 of the European Social Charter.
[73] See Article 22 (b) of the European Social Charter.
[74] See Article 12 of the European Social Charter.
[75] See Article 11 of European Social Charter

Europe[76] is faces problem of obesity. The health obstruction which Europe faces mainly is that there are a lot of differences between the main Europeans and the other legal Europeans of third world, or the migrated people. Multi-culture creates differences in delivery rituals. Receiving of funding benefits due to too many migrants, it's necessary to provide emergency health care especially for pregnant women, disabled person, children and the elderly person. There shall be more number of equipped health workforces with basic health care or infirmary at school levels. Prevention on accidents as health and safety at work should be a major step.

3.6 Right to Health and UN Specialised Agencies

The right to health implementation under the UN Specialised agency has made the health perspective more widened all the specialised agencies receive the copies of reports on their area of expertise through the SG for their recommendation in the treaty monitoring bodies and same is the procedure that WHO tries to follow by collaborating WHO perspective with the specialised agencies, so in order to know the functioning of the specialised agencies it is important to know about WHO as the WHO is one of the only Subordinate agencies which totally functions on all international health work.

According to Gostin and Mok (2009:9) UN has established WHO to exercise the leadership in global health. WHO (Fact sheet no 31:29) through its constitution is also responsible for shaping the health research agendas, setting norms and standards on health measures with articulating evidence based policy, supplying technical support to countries with monitoring health trends and such examples are like the WHO International Code of Marketing of Breast- milk Substitutes 1981[77] and the 2003 Framework Convention on Tobacco Control.

[76] In WHO region of Europe 23% of women are obese. Also see Global Health Observatory (GHO) (2012) Obesity: Situation and trends.

[77] The governments are required to adopt these codes as by not be provided any promotion or advertisement on the breast milk substitutes to the general public, nor shall the pregnant women be supplied with free samples of any breast milk substitutes.

Following the preview of directing the monitoring mechanism of the WHO it functions with the help of other UN agencies like the United Nations International Children's Emergency Fund (UNICEF) 1946, The Joint United Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP) 1996, International Labour Organisation (ILO) 1919, Food and Agriculture Organisation (FAO) 1943, The International Bank for Reconstruction and development (World Bank, IBRD) 1944, The United Nations High Commissioner for Refugees (UNHCR) 1949 and etc.

3.6.1 The Structure of World Health Organisation

3.6.1.1 The WHO Board and Members

The World Health Organisation works through its Article 9 having: a. *the World Health Assembly* (WHA), b. *the Executive Board* members works with its own rule of procedural[78] having its own Chairman elected among its own members for three years plus can be reelected[79] and c. *the Secretariat* of the Constitution of World Health Organisation comprises the Director General (DG) and such experts and administrative staffs required by the Organisation[80] The DG is appointed by the nomination of the Board and elected by the HA decision and the DG is the chief technical and administrative officer of the Organisation[81] and the DG is the ex-officio Secretariat of the HA of the Board of all commissions and committees of the Organisation and of the conferences convened by it further delegates these functions[82], The DG appoints the Staff of the Secretariat under Article 35 according to staff regulations established by the HA through geographical basis recruitment with the efficiency and integrity of the employed staff with international representative character assuring the highest level of the Secretariat.

[78] See Article 27 of the Constitution of World Health Organisation.
[79] See Article 25 of the Constitution of World Health Organisation.
[80] See Article 30 of the Constitution of World Health Organisation.
[81] See Article 31 of the Constitution of World Health Organisation.
[82] See Article 32 of the Constitution of World Health Organisation.

The WHA is composed of delegates representing Members[83] and Article 11 submits that there shall not be more than three delegates for each member and one of them will be the chief delegate. These delegates are chosen among the most qualified technical competence in the field of health, preferably representing the national health administration of that State from where he/she is chosen. There will be alternates and advisors accompanying the Delegates.[84] The Health Assembly (HA) meets for regular annual session in fixed country or region every year selected at each annual session by the HA and in such special sessions the Health Board subsequently determines the place and fixes it and as may be necessary convened at the request of the board or of a majority of the Members[85] and the Board after the consultation with the SG of UN under Article 15 determines the date of each annual and special meeting. The HA elects its President and other officers at the beginning of each annual session and with Article 16 they hold office until new appointments are made. Under Article 17 the HA adopts its own rules and procedure and headquarters location for the organisations shall be determine by the Health Assembly (HA) after the consultation with the UN[86] and define the geographical area desirable to establish the regional organisation to meet the special need of such area having not more than one regional organisation for regional arrangements,[87] by means of regional committee and regional office[88] and meet as often as required deciding their own place of meeting adopting their own rule of procedure.

3.6.1.2 The Health Assembly (HA)

The functions of the HA under Article 18(a) to 18(m) determines the polices of the organisation through establishing such committees as may be considered desirable, naming the designated members who are serving in the board, supervises the financial policies and reviews the approved budget of the organisation, appoints the Director General (DG), reviews and approves reports and activities of the Board and of the DG

[83] See Article 10 of the Constitution of World Health Organisation.
[84] See Article 12 of the Constitution of the WHO.
[85] See Article 13 and 14 of the Constitution of the WHO.
[86] See Article 43 of the Constitution of the WHO.
[87] See Article 44(a) and (b) of the Constitution of the WHO.
[88] See Article 46 of the Constitution of the WHO.

and instructs the Board in regard to the matters where report, investigation, study, action can be considered, instructs the Board and the DG to bring to the attention of Members and of international organisations, governmental or non-governmental regarding any matter which may be considered appropriate by the HA as well as inviting representative who do not have right to vote in the those of the committees and conferences convened under its authority, on conditions prescribed by the HA however the Government concerned is required in the national organisation. Considering recommendations by the GA, the Economic and Social Council, the Security Council or Trusteeship Council of the UN on health reports the step taken by the organisation giving effect to the recommendations.

Report on the agreement between WHO and UN to the economic and Social Council. Establishes its own institute or co-operation with official and non-official institutions of any member with the consent of its Government to promote research in the field of health by the personnel of the organisation and establish such other institute which may be desirable and by taking any other appropriate action by furthering the objective of the organisation, with respect to the competence of the organ the HA has an authority to adopt conventions or agreements. And each member under Article 59 has the right one to vote for HA and decisions shall be made by two-third majority vote of the present vote where the question of adoption of the Conventions or agreements with the approval of bringing Organisation in relation with the UN and intergovernmental organisation and agencies in accordance with the cooperation of Articles 69, 70 and 72 with amendments to the constitution[89] and also two-third present and majority vote is required on any question including the determination of additional categories[90] and voting on analogous matter is going to be by the Board and the Committee of the Organisation in accordance to Articles 60(a) and 60(b).[91]

3.6.1.3 The Executive Board

The Executive Board consists of thirty four designated members with an account of equitable geographical distribution and not less than three shall be from each regional

[89] See Article 60(a) of the Constitution of the WHO.
[90] See Article 60(b) of the Constitution of the WHO.
[91] See Article 60(c) of the Constitution of the WHO.

organisations established under the regional arrangements of Article 44 and each member shall appoint a qualified person in health who can be accompanied by alternates and advisors to the Board[92]. The Executive Board meets twice a year determining the place of its meeting[93]. The board under Article 28(a) to (i) gives effect to the decisions and policies of the HA, acts as an executive organ of the HA by performing on all other functions entrusted to it by the HA, however advices the HA on the matters related to the organisation referred to it by conventions, agreements and regulations to it through that body. The executive board also submits advice or proposal to the HA on its own initiative and prepares agenda for meetings of the HA for approval and consideration of programmes for specific period. It studies all the questions within its competence, by taking all financial and functioning emergency measures of the organisation dealing with immediate actions authorising the DG to take necessary steps to combat epidemics, with health relief to victims of calamity by drawing the urgency of the Board through doing research with studies to bringing in their attention with the help of any member or the DG. The Board exercises on behalf of the whole HA and the powers delegated to it by that body.[94]

3.6.1.4 The Secretariat

In the Secretariat the DG or his representative by the Article 33 establishes a procedure to discharge his duties on direct access to their various departments especially relating with the health administrations and the national health organisations, governmental or nongovernmental with the help of the members agreement. The DG also establishes direct relations with International Organisations and keep all regional offices informed on every matter relating their respected areas. The DG by Article 34 submits all the calculations of financial statements and budget of the Organisation to the Board. The staff of the Secretariat shall conform to the service of the organisation and those of other UN Organisations.[95] The DG and the Staffs during their performance shall not receive any instructions from the

[92] See Article 24 of the Constitution of the WHO.
[93] See Article 26 of the Constitution of the WHO.
[94] See Article 29 of the Constitution of the WHO.
[95] See Article 36 of the Constitution of the WHO.

government or from any other authority external authority to the Organisation. They shall resist all the actions which might reflect on their position as international officer and each member must as well undertake to respect the exclusive character of the DG and the Staff and not to influence them.[96]

3.6.1.5 The Regional Committee

The Regional Committee has a regional Director as a head who is appointed by the Board in agreement with the regional committee[97] having the DG as the general authority the regional office will have the administrative organ of the regional committee and carry out within the region the decision of the HA and of the Board. The regional committee tries to formulate the governing policies of regional character, supervising the activities of regional office, providing suggestion to the regional office by calling technical conferences and with additional investigation or work in the matters relating to the health where the regional committee will promote the objectives of the Organisation within the region by cooperating with the common interest of the regional committees of the UN and those other specialised agencies having same objectives, provide tender advice to the Organisation through the DG where the health matter is international and wider than regional significance, give recommendation to additional regional appropriations by the government when the proportion of central budget is insufficient to carry- out the regional function in that respective region[98] and such other functions that can be delegated to the regional committee by the HA, the Board or the DG.

3.6.1.6 Budget of the WHO

A special fund to be used at the discretion of the Board during the emergencies and unforeseen contingencies is laid under Article 58, where the DG under Article 55 submits the estimated budget of the organisation to the Board, the Board submits it to

[96] See Article 37 of the Constitution of the WHO.
[97] See Article 52 of the Constitution of the WHO.
[98] See Articles 50(a), 50(b), 50(c), 50(d), 50(e), 50(f) and 50(g) of the Constitution of the WHO.

the HA with the advisable recommendations of the Board and by the subject to any agreement the HA will review the approved budget and the expenses among the members allocated by the fixed scale through the HA.[99]

3.6.1.7 Reporting Procedure

Under Article 61 each member shall report annually to the organisation on the action taken and progress achieved in improving the health of its people. With the respect to the convention, agreements and regulations each state shall report on the recommendation actions by the organisation[100] and each member shall provide with the published health concern in the State important laws, regulations, official record and statistics[101] of epidemiological reports as determined by the HA[102] and each member shall transmit as applicable information pertaining on health to the Board as requested.

3.7 The Right to Health and Core Functions of the WHO

There are six main functions of WHO according to the 11th General Programme of Work as "engaging for health" a programme based on budget, resource and result for ten years form 2006- 2015 are (engaging for health (WHO) 2006: iii):

(a) To provide with leadership where there is vital requirement and working in joint-venture when it is required for health engagements;
(b) To formulate with the research agendas and encourage the generation, translation and dissemination on valuable knowledge;
(c) To promote standards and norms on the monitoring implement;
(d) To articulate with ethical values and evidence based policy options;

[99] See Article 56 of the Constitution of the WHO.
[100] See Article 62 of the Constitution of the WHO.
[101] See Article 63 of the Constitution of the WHO.
[102] See Article 64 of the Constitution of the WHO.

(e) To provide technical support, catalysing change, and building sustainable institutional capacity; and
(f) To monitor health situation and asses in health trends.

3.7.1 The Achievements of WHO

WHO achievements so far (Working for health (WHO) 2007: 4-5): In 1948 WHO took over ICD (International Classification of Disease) 1850 known as International list of Causes of Death. Presently, the ICD has works on the International Standard used for clinical and epidemiological purpose. Then in 1952 the first successful polio vaccine was developed by Dr. Jonas Salk (US), subsequently in 1967 the first heart transplantation was conducted by Surgeon Christiaan Barnard of Africa. Later**,** the WHA adopted a resolution in 1974 to bring basic vaccines to all the world's children by the expanded programme on immunisation, and in same year the programme on the control of Onchocerciasis[103] was made. Further, in 1977 the first essential medicine list was published and after two years the WHA published the essential drugs and national drug policy. In 1967 to 1979 the smallpox eradication campaign was made throughout the world and in 1979 first time the major infectious disease was eradicated. The first international conference 1978 on Primary health care was made in Alma-Ata, Kazakhstan as "health for all" and WHO still follows this aspiration. In 1988 the global polio eradication initiative was made as "the goal to eradicate polio worldwide so that no child will ever again be paralysed by this disease". In 2003, Severe Acute Respiratory Syndrome (SARS) was recognised and controlled moreover, in 2003 first time WHO framework Convention on Tobacco Control came up implementing the Convention on Tobacco. In 2004 the global Strategy for diet, physical Activity and Health was adopted which helps to fight against heart disease, stroke, diabetes, cancer and obesity- related conditions. This global strategy helps in making them more physically active by eating healthier diets and during 2005 World Health revised the International health Regulations (IHR).

[103] Infestation with slender threadlike roundworms (filaria) deposited under the skin by the bite of black fleas; when the eyes are involved it can result in blindness; common in Africa and tropical America (River blindness).

3.8 Summation

The countries have legal obligation to implement rights recognised in those treaties which the State Parties have ratified. The monitoring bodies are established under respective Conventions primarily to implement the provisions of the respective Conventions. As discussed, in preceding chapter that the right to health is not a full fledged right, but it is a component of the right to life. Therefore it is implied that while the monitoring body functions in order to implement the right to life and while implementing the socio, economic and political right which includes the right to life. Therefore, the right to health is a combination of various rights. So in order to formulate the rights as a legal obligation on the country, the state parties to these treaties accept to submit regular reports. The initial submission of report is made in one year (two years for CRC) after ratifying the treaty and later in compliance with the provisions arrangements set therein (generally in four or five years) in addition to this the treaty bodies may also receive complaints from the non-governmental organisations (NGOs), UN agencies, other inter governmental organisation (IGO), academic institution and press on the conduct of the countries, based on this dialogue and commitments the Committee publishes its concern and recommendations, referred as "concluding observations". So far, there is no complaint made in HR bodies. Though there is Complaint Mechanism. It is hard to find any complaint registered before these Committees.

At the Regional level it has been observed that the African region faces more health issues compared to the European and American levels. The African region not only faces health problems but it also deals with major ethnical and traditional or religious practices, having genocides and violence with low literacy rates, which is comparatively different in America (Latin and Afro-American) and Europe (Settled-Migrants) region. Since America and Europe is facing more problem of obesity on the other hand African region faces more under nutrition, Europe and America have more health insurance realising the right to health through progressive realisation, but in the African region being a resource poor State and having heavy health problems with less funding brought the initiative of collecting 15% of annual budget of the country is to be utilised in health.

The Americans and European region are far more ahead of gathering money not only for their own people but also for those people worldwide. America is only the industrialised country who spends the maximum amount on health as estimated in 2007 approximately 16.2% GDP is spent and still does. At the UN agencies level the WHO, UNICEF and UNAIDS together work for all health issues where UNICEF looks more into child health and UNAIDS in the patient of HIV/AIDS. So far, WHO is the only full-fledged functionary on health related issues, dealing on infection, diseases, problems of old-age person, children, women or pregnant women with pre and post natal implications or issues, migrants, refugee, person in prison, and so on. The Right to Health Monitoring Body, not just implements the health rights. But, also Monitors how the Countries or States have implemented the laws or legislative in their States, and tries to recommend suggestions on the upcoming challenges on health. The individuals are also protected through the distinct features of monitoring body and provided with those rights which not only State has to provide. But, all other countries too have to cooperate in achieving the right to health for individuals.

CHAPTER- IV

The Right to Health: An International Law Assessment

In this chapter, the right to health by emerging jurisprudence will be studied through the case laws of international courts, institutions and human rights committees' including regional human rights courts. Special focus will be placed to find out various forms of discrimination by laws and practices done by the state(s) and the society on the basis of economic, socio, race, place, sex and disease.

4.1 The Fundamental Principles of the Right to Health

The realisation of right to health at any point includes availability, accessibility, acceptability and quality. The General Comment no.14 in its para 12(a), 12(b), 12(c), and 12(d) states these four essential elements as the necessary requirement for the right to health care system at every stage, which also depends on the provisions provided by the State Parties. They can further be elaborated as:

4.1.1 Availability

Availability means that every State Party has to provide sufficient facilities, goods and services to all vulnerable or needy individuals including those affected by the determinants of health like the right to safe and potable drinking water, essential sanitation services, hospitals, clinics and other health-related buildings providing basic health care facilities besides emergency situations, round the clock trained medical and professional persons for health services receiving domestically competitive salaries and essential drugs as defined under the WHO Action programme on essential drugs.

4.1.2 Accessibility

The accessibility of health care facilities, goods and services involves four dimensions concerned with non-discrimination they are physical, economic and information accessibility and infrastructural discrepancies. The right to Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities), but does not impair the right to personal health data treated confidential.

4.1.3 Acceptability

Acceptability means when all the health facilities, goods and services are provided while upholding the pursuance of medical ethics which are culturally appropriate (communication and other ethical issues) and are designed to value confidentiality or privacy, as well as improving the health status of concerned individuals. The facilities, goods and services should also respect gender-sensitivity and they should be scientifically and culturally accepted.

4.1.4 Quality

Quality means the facilities, goods and services provided are scientifically and medically appropriate and of good quality. These qualities of arrangements point towards the availability of skilled medical professionals during emergencies; providing well equipped facilities required to the individuals; issuing safe and approved hospital equipments and drugs for patients; supplying safe and potable drinking water to all; providing proper nutrition to tackle health challenges and proper sanitation. The quality of services must be scientifically and medically appropriate and of good quality.

4.2 The Essential Elements Embedded in Right to Health

Essential elements, which if breached will lead to the curtailment of major health rights. These elements are confidentiality, discrimination, consent, disability, rights of the patients and rights to access medicine.

4.2.1 Discrimination and the Right to Health

Discrimination normally means unlawful exclusion (debarment/ banishment) of acts done by society (abusing or stigmatising) or formal institutional (job, health services etc.) and legal (quarantine and restricting measures) settings which deny individuals the right to access, afford, accept and acquire quality health services and care. The discrimination related to health according to the General comment No. 14 para. 18 can be made on the grounds of race, color, sex, religion, language, national or social origin, political or other opinion, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. These conditions are based on accessibility of health care and its underlining determinants and the means to entitlement of their procurement.

The UDHR in its Articles 1, 2 and 7, the ICCPR in its Articles 2(1) and 3, American Convention on Human Rights (ACHR) in its articles 1(1), African Charter on human and Peoples' Rights in its Articles 2, 3(1) and 3(2), and the European Convention on Human Rights in article 14 all together have tried to state that the health rights shall be secured through non- discrimination. But, the International Health Regulation (IHR) 2005 according to Article 2 provides for preventive, protective, controlling public health measures during the international spread of diseases, however these defensive health procedures mostly restrict the foreign travelers at the point of entry (IHR Articles19-23) like ports, airports, international borders etc. This leads to, discrimination towards those individuals who suffer from non-contagious diseases and still face screening on their arrival, which is definitely not required.

Today at least 106 countries have HIV(+) specific travel restrictions, while 13 countries have completely banned HIV(+) people from entering into their territory and around 20 countries follow rigid policies like the proof of being HIV(-) (Rev. Annie Kaseketi, 2008: 3). These measures in fact not only violate the right of availing health facilities or services in another country but also denies them (people living with HIV(+)) from the fundamental principles of the right to health.

The General comment no. 14 on the highest attainable standard of health (2000) para 18 and 19 also states that health discrimination can be prosecuted through minimum resource implication by adopting, modifying or abolishing the legislation or by spreading of information. But, the expensive curative health services are often accessible only by small privileged fraction of population, rather than benefiting far larger population on primary and preventive health care. For example: in the case of Soobramoney v. Ministry of health[1] (1997) Kwazulu-Natal South Africa where a 40 year man was suffering from ischaemic heart and cerebo-vascular disease since 1996 had a kidney failure and reached the last stage of chronic renal failure but was still not allowed to take regular renal dialysis from the renal unit of the Addington State Hospital in Durban due to lack of resources and even the Court further elaborated that the government cannot provide 70% of people suffering like Mr. Soobramoney similar resources as the burden of health services borne by the government is R[2] 60,000 per annum per patient, thus the provision of this service to an individual may disturb the health budget and do injustice to other obligations that the government has to meet. So far in this course of the order it is felt that sometimes the discrimination can not only be the insufficient funds of a State but it is also based on the discrimination made on how many population are going to undergo the treatment. Further to add up with the case the General comment no. 03 in para 12[3] rightly points towards the resource poor condition, where the indication falls for the vulnerable most societies and their protection and these targeted programmes have to be first adopted by relatively low cost.

[1] (CCT32/97) (1997) ZACC 17;1998 (1) SA765 (CC); 1997 (12) BCLR 1696 (27 November 1997)
[2] R means South African Rands. The Rand is the currency unit in South Africa.
[3] Also see. General comment no. 14 para 18

The Committee on Elimination of Discrimination against Women under Articles 10 and 12 of the Convention through its General Recommendation No. 14 of ninth session 1990 dealing with female circumcision[4] has taken note of the recommendations of the Special Rapporteur and stated that the State Parties shall adopt all measures to eradicate such practices following female circumcision. Sinha (2008:8 and 10) rightly argued based on the epidemic of HIV/AIDS that discrimination, stigmatisation and denial (DSD) is not only affecting the lives of families, communities, workplaces, schools and health care setting. The only way to overcome this is by replacing shame with solidarity and fear with hope.

4.2.2 Confidentiality or Privacy

The UDHR in Article 12, the ICCPR in Article 17, American Convention on Human Rights (ACHR) in Article 11 and the European Convention on human Rights in Article 8 emphasise on the protection of privacy and confidentiality of patient's information. The physicians and other health care workers have a moral duty to maintain patient's privacy. Which, if not carried out will disrupt the level of confidence shared by the doctor and the patient leading to the patient not disclosing the real nature and facts about his/her illness jeopardising proper diagnosis. The doctor should generate full faith in the patient by disclosing and sharing proper information and facts with the patient. Furthermore, seeking such a relationship where both the doctor and patient share confidence enables the physicians and other health care workers to identify the appropriate treatment for the patient and the patient can properly address his/her problems.

However, if the patient's medical information is disclosed or revealed to a third person then the patient might face discrimination, stigmatisation, denial and humiliation from the outside world or from his/her own family/relatives and spouse.

[4] This may lead to short or long term implication where haemorrhage (bleeding), infection and acute pain are the immediate consequences. Keloid formation (scare or dead tissue formation), infertility as a result of infection, obstructed labour and psychological complications, These practices when down by untrained attendants may also lead complications in resulting deep cuts or death dew to infected instruments or infect other organs due to haematocolpos (inability to pass mensural bleeding)

The case of Mr. X v. Hospital Z (1998) SC 3662[5] can be cited to strengthen the aforesaid, where the disclosure of appellant HIV (+) status resulted in the cancellation of the appellant's marriage. This event further resulted in stigmatisation and criticism of the appellant banishing him from his own community. Moreover, the right to privacy was culled out,[6] from the right to life and right to healthy life of Indian Constitution. As the Court observed that there are two clashes of fundamental rights as the right to privacy as part of right to life and right to lead a healthy life under Article 21 of the Indian Constitution, the right that advances the public morality or public interest would only be enforced by the court. This decision proves that sometimes the right to privacy is not treated absolute Human Rights, where there is threat of affecting others life.

4.2.3 Consent or Human Experiment

The right to consent under the right to health means when the patient understands and acknowledges his/her consent through a written or verbal medium for his/her receiving a treatment or authorising the treatment with the sharing of private information or voluntarily accepting the treatment. The ICCPR in its Article 7 has rightly said that without the consent of an individual no medical or scientific experiments can be done. The Human Rights Committee General Comment No. 20 (1992) in this regard has also pointed out that the State parties to ICCPR ought to report under Article 7, the full information regarding the prohibition on medical and scientific experiment which is done without consent of the concerned person. The Committee has also observed that protection is necessarily required to safeguard those individuals who are not able to provide valid consent, further the Committee elaborates that persons who are detained in prison shall not be subjected to any medical or scientific experiment without the consent of the individuals as this may put their health at risk.

[5] AIR 1999 SC 495, JT 1998 (7) SC 626, 1998 (6) SCALE 230.
[6] The culled out means the selection made on the desirable (worthy) basis. The case highlights on the Article 21 of the Indian constitution read with Directive Principles of State Policy.

Instituted on the grounds of consent, based on the permissible experiments and contributing in the development of the biomedical research and bio ethics the well contributed Nuremberg Code[7] (1947) principles strongly states that justification should always be made on experiments executed on human- beings, whether these experiment results for the benefit of society that are unprocurable by other methods or means of study, and if voluntary consent on the experiment is provided then it should be based on free power of choice, having sufficient knowledge and understanding of the elements of the issue and having awareness of the subject matter involved in the experiment. Still if, any experiment that is believed to cause death or disability injury the experiment should not be conducted. The Geneva Convention and the 1977 protocols provisions based on international humanitarian law have also prohibited on the human experiment done without their consent and knowledge. The WHO Proposed International Guidelines on ethical issues in Medical Genetic and Genetic Services 1997 has also addressed on the experimentations done on the human. Thus various legal efforts have been put to prohibit the human experimentation without free consent and these efforts try to protect the personal autonomy of an individual, determining on their health status (Kumar, 2007: 70).

For instance, the voluntary trial of AIDS vaccine[8] by healthy people who are 18 and above and who are not HIV+ in order to find safe and effective HIV vaccine for protecting other individuals can be mentioned as an example. In regard to such experiments, the International Ethical Guidelines for Biomedical Research Involving Human Subjects 2002 (Marks 2004: 17) also states in its guideline 4 that the investigator must take informed consent of the individual about the experiment and if that individual provides voluntary consent then that individual can be sought voluntarily. This practice also legalises all authoritative, for the informed consent but before proceeding it needs to get approved by the ethical review committee.

The right to consent should be received voluntarily, in order to accept the medical or scientific experiment. Such medical or scientific experiment should be

[7] Also see Stephen. P. Marks (2004:9-10) and Nuremberg Code (1947) U.S. G.P.O, 1949-1953, 2:181-182.

[8] AIDS vaccine trial run by the HIV Vaccine Trial Network, funded by the National Institute of Allergy and Infectious Diseases (NIAID) of the National Institute of Health (NIH). Also see Clinical Research sites conducting NAID supported HIV Vaccine Trails- 2009.

conducted only after taking the consent from the individual on whom the experiment is going to be carried on, the right to consent is always complete when the consent is taken through the conscious mind and after making proper acknowledgement of the knowledge on that experiment.

4.2.4 Rights of the Patients

All patients[9] have the same equal right to access health care but the States authority can, at times restrict personal liberty for public health purpose by taking certain steps and actions to ensure public safety. An example is the case of Jacobsen v. Commonwealth of Massachusetts[10] (1905), in this case during the outbreak of smallpox (1902) in Cambridge. The city's health board came with a compulsory vaccination to stop the spread of the disease or to pay a fine of $5 for refusing the vaccination. Hence, Mr. Jacobson refused vaccination believing that he and his son had developed some complications due to the vaccination administered earlier and assuming that they were being subjected to scientific tests. So, Mr. Jacobson filed a case under Massachusetts State constitution contesting that the compulsory vaccination violates the state and constitution of the USA but the Supreme Court on 20th February 1905 upheld the decision that during the outbreak of an epidemic the freedom of individuals should be subordinated sometimes in order to provide common public welfare and impose police power.[11]

Sequentially, under the Principles of the Rights of Patients in Europe 1994 taking account of provisions which are embedded in UDHR 1948, ICCPR 1966, ICESCR 1966, the European Convention on Human Rights and Fundamental Freedom 1950 and the European Social Charter 1961 endorsed by WHO European

[9] Users of health care services, whether healthy or sick.
[10] 197 U.S. 11. And also see Mariner, Wendy. K., Annas, George. J., and Glantz. Leonard H. (2005) "*Jacobson v. Massachusetts: It's not your Great- grandfather's Public Health Law*". Am J Public Health. 2005 April; 95(4): 581–590.
[11] In the case of Gibbons v. Ogden 1824 the Chief Justice John Marshall (the longest serving Chief Justice of US (1801-1835)) stated the police power means "that immense mass of legislation, which embraces everything within the territory of a State, not surrendered to the government" Or according to the constitution of US those affected rights of individual when those rights conflict with the promotion and maintenance of health, safety, morals and general welfare of the public.

Consultation[12] (Marks 2004: 33-36). The right of patients has been formulated in order to provide information on the health services and their conditions benefiting the patients with instructions on diagnosis, prognosis and progress of treatment. The right of the patient also entails the provision of his/her consent to the medical intervention, confidentiality and privacy of the patient's information even after his/her death is the right of a patient. The right to receive care and treatment in accordance with the requirement of his/her health needs is also one of the patient rights wherein, his or her financial, human and material resources shall not be the medium of discrimination. The patient has the right to enjoy support from family, relative and friends, but he/she also has a right to die with dignity.

The major realisation of the rights of the patient was made possible when the European scale Recommendation No. R (97) 5 of the Committee of Ministers to Member States on the protection of medical data, which was adopted by the Committee of Ministers on 13 February 1997 at the 584th meeting of the Ministers' Deputies provided the facilities in the development of international standards, through international mobility and international exchange, in the field of medicines, protecting all the personal medical information through dignity in computerised format departing from the old sophisticated biotechnology and medical information systems in both the private and public sectors.

4.2.5 Disability and Right to Health

According to the UN Standard Rules for the Equalisation of Opportunities for people with disability 1993 (Resolution 48/96) the definition of disability summarises as different numbers of functional limitations like mental illness, intellectual or sensory impairment, physical, permanent or transitory in nature. Article 25 of the Convention on the Rights of Persons with Disabilities 2006 rightly states that all individuals have the same right to enjoy the highest attainable standards of health without being discriminated on the basis of their disability. Principle 1 of the Persons with Mental Illness and the Improvement of Mental Health Care[13] (1991) states that as a part of

[12] Attended by 60 persons from 36 member States, meeting in Amsterdam from 28- 30 March 1994.
[13] adopted by the General Assembly Resolution 49/119.

fundamental freedom and as a basic right also points out that every individual has a right to best available mental health care which should also be part of health and social care system.

The General Recommendation No.18 in tenth session, 1991 on Disabled Women under Article 3 of the Convention recommended the State parties to provide periodic reports on disabled women. The General Comment No. 5 on Persons with Disability 1994 also attempts to link disability with economic social and cultural rights by stating that the basic needs of all i.e. food, water, shelter, health protection and education even in the countries with relatively high standards are often denied to disabled persons. The General Comment No. 5 further observes that discrimination on the basis of disability still occurs in the field of education, employment, housing, transport, culture life with access to public places and services when it is the duty of both the public and private health sectors to provide health facilities without discrimination.

4.2.6 Right to Access Drugs

The fundamental requirement of the right to health is equitable access to essential medicines which saves life from epidemic or endemic diseases. According to B. C. Nirmal (2009:1) the right to access a drug is governed by numerous factors and the most important among them is the price of drugs, but if the pricing of drug is carried out under a strong patent regime[14] then it will not only increase the drug prices but also deny its accessibility to the vulnerable and marginalised population. The WHO (Essential Drugs and other Medicines (traditional medicines)) has delineated four key objectives, (i) strengthening national medicine policy; (ii) improving access to essential medicines; (iii) the quality and safety of medicines; and (iv) their rational use, as of immense importance.

[14] B.C. Nirmal believes that the TRIPs Declaration and paragraph 6 Decision does not solve the fundamental issues of equal access to rights and access to medicines in a satisfactory manner, so further with the help of Thai Minister of Public health, he (Nirmal) concludes to say that the government of developing countries need to provide special care to their respective pharmaceutical industries so they can survive in such highly competitive global market.(2009 :405 and 407)

The right to access drugs also provides the patient with the right to take safe drugs and drugs within expiry limit, as the consumption of expired medicines can lead to health complications. The right to access drugs also provides the patient the right to be taken to governments' arrangements or facilities where his /her vulnerable condition does not allow him/her to afford the treatment. The right to drugs does not allow patients to be used as a subject for an under trial experiment who themselves are unaware of the treatment they are taking.

The government has legal obligation for providing access to basic medicine, physically and economically, as well as providing information relating to accessible medicine to the public. So far, the government has a legal obligation to provide basic drugs through the priority of States budgetary system, however financial credit should not be the only provision of the health care system, but it should also balance out other priorities like pricing, licensing, competition and other laws. Other factors that may facilitate the access to essential drugs are rational selection use of medicine; sustainable adequate financing; affordable prices; and reliable health and supply system (Kamayani Bali Mahabal 2004: 35-37).

4.3. Marginalised Population and Right to Health

The most vulnerable and marginalised population are the women, children and adolescents, old-people, prisoners, injecting drugs users and sex workers.

4.3.1. Women

Women in comparison to men, due to the burden of societal arrangement, are high on the degree of vulnerability as shown by the health indicators. Thus, the International Convention on Economic, Social and Cultural Rights and the Convention on the Elimination of All forms of Discrimination try to exclude discrimination practices against women in the health care system and assures them equal access, as men, to health- care services. The Committee on the Elimination of Discrimination against Women further in the General Comment No. 15 of ninth session (1990) urges nations to follow preventive and control strategies to mitigate Acquired Immunodeficiency

Syndrome (AIDS) and recommend the nations to provide public awareness on the risks of HIV/AIDS especially, and focus on the vulnerable position of pregnant women and children.

The General Comment No. 19 of eleventh session (1992) states that the compulsory sterilisation or abortion affects physical and mental health of women and infringes upon her decision on the number and spacing of children. Family or domestic violence also puts women health at risk and impairs her ability to participate in family and public life. The Beijing Declaration[15] also deals with the issue of reproductive rights of women.

In 1973 for the first time the Court itself moved towards transformation in particular with Science, as in the case Roe v. Wade[16] (1973) where the petitioner Jane Roe,[17] an unmarried pregnant woman twenty three years old wanted to abort her third child,[18] but abortion in Texas was illegal. Questioning the Texas Law,[19] in the interest of Roe and other pregnant women who wanted to have an abortion a case was filed in the Federal Court on 3rd March 1970,[20] in this suit it was claimed that the Texas law was unconstitutional under the first, fourth, fifth, ninth and fourteen amendments to the right to privacy guaranteed in the constitution bills of right and later through Supreme Court (SC) verdict on 22nd January 1973 she won the case, as the SC with seven to two ruled that the Texas abortion (for first trimester when the foetus[21] right emerge to possibility of existing or when it can survive independently) law was unconstitutional, which made abortion a constitution right to privacy as a right for

[15] Beijing Declaration adopted at the Fourth World Conference on Women in September 1995. para. 17 of the Declaration provides "The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment".

[16] 410 U.S. 93 S. Ct. 705, 35 L. Ed. 2d 147 along with the case of Doe v. Bolton, 410 U.S. 179, 93 S.Ct.739, 35 l. Ed. 2d 201 (1973) as it was a companion complaint to (Roe case) relating to 1968 Georgia abortion statute.

[17] Pseudonymously named in order to hide the real identification (anonymity) of the lady from all the social pressure or discrimination she would have faced, but in later days she (Norma McCorvey) revealed herself in public through some TV shows and also through the book she wrote in 1994 as "I am Roe: My life, Roe v. Wade, and Freedom of choice".

[18] Jane had given her one daughter from her first marriage to relatives after divorce and later on gave the two more kids including the Roe suit child for adoption.

[19] Abortion in 1857 Texas statue was considered illegal and criminalised as at that time only when the mother's life was in danger or she was raped then only she could avail abortion.

[20] Roe was six months pregnant and an alone mother with no financial backup living in the free century of 60's. In later days she gave birth to her child and still continued to for the women's right to abortion.

[21] An unborn child in the later stages of development showing the main recognisable features of the mature human-being.

abortion without government's undue influence by affirming that the prenatal rights rises as the pregnancy months increases or advances. The right to health of Women under the General Recommendation No. 24 (20th session, 1999) requires all health services to be consistent with the human rights of women as well as with the rights to autonomy, privacy, confidentiality, informed consent and choice.

4.3.2 Children and Adolescents

The Fact Sheet No.31 on "The Right to Health" (2010: 14) states that the physical and mental developmental stage of children provides them with particular health challenges which make them more vulnerable to malnutrition and infectious diseases, and when they reach adolescence to sexual, reproductive and mental health problems. Further the Fact Sheet No 13 on "The Right to Health" (2010:15) states that children and adolescents are more vulnerable to the risk of HIV/AIDS as the child can acquire the virus through the mother[22] in many regions the HIV infection are heavily concentrated among young people (15-24 years of age).

There is also a need to adopt effective and appropriate measures to abolish the harmful traditional practices which affect children particularly girls like the practice preferential feeding and care of male child (especially where patriarchal system is followed), and children with disability should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community (General Comment No.14, 2000 para 22). The Convention on the right to Child 1989 in its Article 24 has stated that the State parties ensure that all children can exercise the right to access health care services and facilities for the treatment of illness and rehabilitation. The State parties also need to take measures to control child and infant mortality rates with pre and post natal health care for mothers and even ensure that all segments of the society are informed and have access to education and know about child health and nutrition, advantages of breast feeding and sanitation etc.

[22] The baby can get affected through mother, as mother to child transmission because it has been observed that during pregnancy 25-35% of chances are there to get infected as well as even during the process of breast-feeding and child birth).

The General Comment No.4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003) has stated that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. The adolescent girls as well as boys equally should be provided information on the harm of early marriage and early pregnancy and those, who become pregnant, should be provided with health services. Sometimes the young mothers especially where support is lacking may be prone to depression and anxiety, compromising their ability to care for their child. So in this regard the Committee urges States to provide sexual and reproductive health services including family planning, contraception and safe abortion service where abortion is not against the law with child birth and child care counseling.

4.3.3 The Rights of Old- People

The Medical Association Declaration on the Abuse of Elderly (1990) has pointed out that elderly patients require assistance for their daily activities as they usually suffer from pathological problems such as motor disturbances,[23] psychic[24] and orientation disorders,[25] however in reality the families and communities try to limit their care and services to minimum and consider them as burden.

The General Comment No. 6 of the Economic, Social and Cultural Rights of Old Persons (1995) under its Article 12 Para 34 and 35 also states that the realisation of the right of elderly persons should enable them to enjoy decent standards of physical and mental health, ranging from preventive, curative and rehabilitative health treatment of chronic and degenerative diseases and protection from high hospitalisation costs. In this regard, the measures should include regular check-ups for both the sexes; physical as well as psychological rehabilitative measures for maintaining the functional capacities of elderly persons; adoption of healthy lifestyles

[23] Motor disturbances means disturbances in the way people move.
[24] Psychic means when a person apparently sensitive to things beyond the natural range of perception.
[25] Orientation disorder means when memory that grossly impairs a person's behaviour, judgment, capacity to recognise reality or the ability to meet the ordinary demands of life.

from beginning (food, exercise, elimination of tobacco and alcohol, etc.) and sparing them avoidable pain and enabling them to die with dignity.[26]

4.3.4 Injecting Drugs Users (IDUs)

Nowadays, the most commonly injected drugs are heroin[27] and other opiates,[28] cocaine[29] and amphetamines.[30] According to Simon Wills the majority of injecting drug users suffers from bacteria, viruses and fungi above all most severe infections among intravenous[31] drug user are through transfer of blood-borne infections between individuals as a result of the sharing of needles, syringes and filters. These infections include human immunodeficiency virus (HIV) and viral hepatitis, tuberculosis and other contagious infections can also spread by affected individuals associating with others. Infections can be difficult to diagnose, but withdrawal from some drugs, most notably opioids, can cause fever without any underlying infection (Wills 2005: 19, 20 and 22).

The advocacy guide for HIV/AIDS prevention among injecting drug users has correctly pointed out that while providing treatment to the IDUs, voluntary treatment tends to be much more successful than mandatory treatment, while lack of serious funding support in many developing and transitional countries lower the capacity and quality of drug dependent treatment (World Health Organisation 2004: 6)

The UN Office of Drugs and Crime HIV Unit on HIV/AIDS prevention and care for female injecting drug users have stressed that females are more stigmatised[32] by society than male injecting drug users and the condition of Female drug injectors is

[26] Also see General Comment No.14 (2000) on the right to highest attainable of health para 25.

[27] A narcotic that is considered a hard drug; a highly addictive morphine derivative; intravenous injection provides the fastest and most intense rush. Heroin is most commonly used in European nations and across Latin America. The name is buprenorphine in France, methamphetamine in South Korea

[28] A narcotic drug contains opium or an opium derivative.

[29] A narcotic (alkaloid) extracted from coca leaves; used as a surface anaesthetic or taken for pleasure; can become powerfully addictive. Cocaine is most prevalent injecting drug in Mexico.

[30] A central nervous system stimulant that increases energy and decreases appetite; used to treat narcolepsy (An inability to stay awake) and some forms of depression

[31] Within or by means of a vein

[32] Their activities are considered to be more deviant and against the accepted norm of traditional beliefs from women as wives, mothers, daughters and nurturers of families.

more vulnerable than men because of the common needle sharing practice after her partner, as it is often impossible for a female to ask for clean injection equipment because it implies that she does not trust him (2006:1).

The best example on this regard can be the recent visit by the UN Special Rapporteur on the right to health, Anand Grover, in Vietnam 2011 where he concluded his mission in Hanoi by stressing that detention and compulsory treatment of injecting drug users and female sex workers in the so-called rehabilitation centers of Vietnam violates their right to health because the detainees are denied the right of consensual treatment as well as the right to be informed regarding all medically related decisions by the centre. He further determines that alternative treatment for injecting drug users shall be brought on, initiating a number of pilot methadone[33] and community-based programmes so as to tackle the practices of stigmatisation and discrimination of those groups in the society.

4.3.5 The Right to Health and Prisoners

According to Moller Lars, Heino Stover, Ralf Jurgens, Alex Gatherer, Haik Nikogosian (2007: 3) prisons are the most complex place to manage, because of too many prisons, serious threatening epidemic diseases, and using of prison as mental rehabilitation. The United Nations (1990) Basic Principles for the Treatment of Prisoners states that all prisoners have access to the health services available in the country without discrimination on the grounds of their legal situation. The prisoners also have the same right to enjoy the highest attainable standard of physical and mental health as stated in the Article 12 of the International Covenant on Economic, Social and Cultural Rights.

So far in relation to the vulnerable situation of the prisoners and denial of right to health the case of Victor Rosario Congo v. Ecuador, Case 11.427[34] is of extreme relevnce. In this case a complaint dated 14th September 1990 was filed on behalf of a

[33]Synthetic narcotic drug similar to morphine but less habit-forming; used in narcotic detoxification and maintenance of heroin addiction.
[34] Report No. 12/97, InterAm.C.H.R., OEA/Ser.L/V/II.95 Doc. 7 rev. at 257 (1997).

mentally ill prisoner[35] Mr. Victor Rosario Congo at the Social Rehabilitation Centre in Machala, Ecuador. He was assaulted with a garrote[36] by the guard named Osorio causing Mr. Congo severe injuries, he was stripped naked and also denied medical care[37] and he was kept naked in the cell for three months. The medical examiners from the office of the District Attorney also confirmed that the prisoner had marks on his body caused by beatings and dirty bruise[38] all covered with mud. On 18th October 1990 the prisoner Congo was requested to be moved immediately to a hospital by the third transfer Agent in El Oro but his late transfer to the Men's Social Rehabilitation Centre in Guayaquil on 24th October 1990, and again to Luis Vernaza Hospital on 25th October 1990 resulted in his death[39] without being subjected to proper heath care. So in compliance with the report 29/99 on 13th April 1999 the Inter-American Commission on Human Rights (IACHR) in the city of Washington approved the agreement.[40]

4.3.6 Sex Workers

The Convention on Elimination of all forms of Discrimination against Women in its article 6 has also stated that the State Parties to the convention shall take all suitable measures, including legislation, to suppress all forms of traffic in women and exploitation of women involved in prostitution. But still the ongoing discrimination

[35]He was prison for robbery, but his mental condition was so unstable that he could not be imprisoned.
[36] Garrote is an instrument of execution for execution by strangulation or strangle with an iron collar.
[37]As he would had been provided with psychiatric facilities due to his mental condition.
[38] An injury that doesn't break the skin but results in some discolouration.
[39]Before the death of Mr. Victor Rosario Congo the NGOs through various ways had requested to move him in a hospital where he could have received proper medication.
[40]where the State of Ecuador had to acknowledge its international accountability by American Convention for the violation of the Article. 4 dealing with the right to life as stated under Article. 4(1), 4(2), 4(3), 4(4), 4(5) and 4(6) of American Convention; Article. 5(1) which deals with every person through American Convention has the right to have his physical, mental and moral integrity respected; Article. 5(2) stating no one shall be subjected to torture or to cruel, inhumane, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person as said in the American Convention; Article. 25 dealing with the right to judicial protection through 25(1), 25(2)(a), 25(2)(b) and 25(2)(c) of American Convention; and Article. 1(1) which says that the State Parties to the American Convention have undertaken to respect the rights and freedoms recognised and insured to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination on reasons of race, colour, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition. And by paying compensation of US $ 30,000 (thirty thousand US dollars).

and stigma encountered by the sex workers clearly highlight their plight and exploitation due to their involvement in prostitution.[41]

The Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, approved by General Assembly resolution 317 (IV) of 2 December 1949, in its Article 16 has also stated that all the Parties to the present Convention shall take or encourage, through their public and private educational, health, social, economic and other related services, measures for the prevention of prostitution and for the rehabilitation and social adjustment of the victims of prostitution and of the offenses referred to in the present Convention. Still the rigorous anti prostitution laws and policies around the globe lead to the imposition of harsh and repressive measures against sex workers. Discrimination and stigmatisation is making it difficult for them to safeguard their own health and lives.

4.4 Obligations of the States and the Right to Health

International human rights law lays down obligations on Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups. They should not be taken away, except in specific situations and according to due process. The 1993 Vienna World Conference on Human Rights, for example, noted that it is the duty of States to promote and protect all human rights and fundamental freedoms, regardless of their political, economic and cultural systems. Some fundamental human rights norms enjoy universal protection by customary international law across all boundaries and civilizations.[42] The International Covenant on Economic and Social and Cultural Rights, article 2 states that each State Party to the Covenant accepts to take steps individually or with cooperation, or guarantee the rights without any discrimination for achieving the progressive or full realisation of rights under the covenant.

[41]Offering sexual intercourse for pay.
[42] Also see 'Vienna Declaration and Programme of Action'1993, adopted by the World Conference on Human Rights.

4.4.1 Realisation of the Right to Health

The progressive realisation of the right to health can only take place when the ratification of the rights provided in the international instruments are properly implemented in State Parties at domestic jurisdictions. The role of international assistance or cooperation by other States Parties also incorporates in helping the realisation of the right to health, when a State Party is not able to protect or promote the right to health through its economic, social and cultural rights[43]. In order to realise the rights there is also a responsibility to guarantee the rights to individual without any discrimination. The Committee on Economic, Social and Cultural Rights has also stated that the enjoyment of the right to health can be achieved by national strategy.

The Committee on Economic, Social and Cultural Rights has also stressed on States core minimum obligations with respect to right to health by respect, protect and fulfill are: The right to access health facilities, goods and services must be provided to individuals through non-discriminatory basis, especially for all vulnerable or marginalised groups; The right to health obligation also carries access to the minimum essential food which is nutritionally adequate and safe; provide access to shelter, housing and sanitation and an adequate supply of safe drinking water for all; there shall be a provision of essential drugs; and equitable distribution of all health facilities, goods and services.[44]

4.4.2 Responsibility for Health[45]

The health is on one hand a highly personal responsibility on the other hand a major concern. It thus involved the joint efforts of the whole social fabric, basically at the level of (i) Individual; (ii) Community; (iii) State; and (iv) International Community to protect and promote health.

[43] Also see the General Comment No. 3 of the Committee on Economic, Social and Cultural Rights (1990) on the nature of State's party obligation and also see General Comment No. 14. Para 38-42.
[44] Also see WHO "the right to health" Fact sheet No.31: 22-25.
[45] Also see (Kumar 2007: 101-110 and Park 2005: 20-21)

4.4.2.1 Individual

The individual have responsibility to share and contribute actively at the level of individual, family, group and community levels. As it is the duty of individual to involve in health care, by developing the ability to define and express their needs and requirements through all informal health related decision making or health activities. The individual responsibility helps in making the realisation of the right to health to its fullest by incorporating self care and self- help, where they can help by family planning, taking measures in health prevention and security, promoting health education to all with help of first aid. Reporting early about any sickness and individually helping each other in order to take the responsibility for health right.

4.4.2.2 Community

The community participation is an essential principle of primary health care approach. Because the understanding of an individual's health care and services lies stronger in its community practice. The community responsibility makes the achievement of health practice stronger when the health facilities have more workforces, assistance or support and more funds. The community has also a responsibility to contribute in health planning, health education, providing management on health facilities and services by taking protective measures for all.

4.4.2.3 The State

The State has maximum responsibility above all, in providing the right to health to each and every individual without any discrimination and difficulties. As it is the Governments responsibility to meet all the health related achievements and challenges by establishing all the frameworks and managerial process in improving the health sector and facilities. It is also the State responsibility in providing budget allotment

towards health with the help of the finance division of the State and the government should also provide funds for weaker section or vulnerable individuals of the State. The Government also has a responsibility to provide free access of medication or health facilities and care where the vulnerable society is not able to exercise those rights. The Government has a responsibility to look at functioning of the Health centers whether they are adequate and sufficient in providing the access of medical sphere and the Government should conduct inspection on health practitioners and the Hospitals or Health centers are functioning efficiently through their knowledge of handling the patient qualitatively and properly. Furthermore, the Government has a responsibility to check that no individual has been violated from receiving his/her right to access health facilities based on social and economical status and whether the state has implemented all the majors for providing right to health to each and every individual.

4.4.2.4 International Community

The strengthening of health infrastructure is only possible when cooperation of governments, nations, the people and international Organisations within UN and outside system help together in achieving the realisation of the right to health. The international responsibility together helps in combating diseases, exchange of experts knowledge, by provisions of drug supplies, and achievements of health strategies and targets of the goals (MDGs), The international responsibility not only helps in achieving the right to health but it also helps in progressively realising the right to health.

4.5 International Organisations and Right to Health

The Jurisprudence of the right to health has been evolving since the day human suffering started. The International Courts (ICJ and ICC) have so far not been able to make or detect any achievements towards the development of the right to health. The

institution especially WHO has been making continuous efforts to achieve the right to health and the ILO and FAO have also come along to support it in the process of realisation of right to health, through their implemented procedures of rights benefits. The regional and human rights court have been one of the initialising platforms for carrying out new measures, in an attempt to realise the right to health to the fullest.

4.5.1. WHO and the Right to Health

The achievement of right to health goal is influenced by the health policies and their arrangements. The WHO emphasise more on formulating policies, strategies and programmes of action rather than laws and the member states are expected to follow the policies, programmes and recommendations being formulated since 1948 (Riedel Eibe, 2009: 23). According to the WHO Outbreak Communication Guidelines (2005: 1-8) in order to promote public health goals, with least possible disruption to the society, the outbreak of the disease should be communicated to public for the safety and security of their health. But still, in making such communication during the outbreak of disease their lies the risk in communication. The components for these outbreak communications are trust,[46] announcing early,[47] transparency,[48] the public,[49] and planning.[50] Therefore, WHO believes, if the guidelines on these components are implemented effectively it will minimise damage to the nations international standing, its economy, and its public health and help the member state to control the outbreak, as far as possible, without social disruption.

[46] The trust plays a vital role between the trust triangle (communicators, technical staff and policy-makers) who have to manage the alarming of the outbreak of disease without making the public panic and by maintaining the accountability, involvement and transparency to establish that trust.

[47] In order to prevent rumors and misinformation about any outbreaks, the communication should be made as early as possible when public behaviour might reduce risk or contribute to the containment of the outbreak. The communication shall also have public acknowledgement that the information may change as further information developed or verified.

[48] The communication should be made in easily understandable language with complete and factually accurate information.

[49]The gap between public understanding and their beliefs has to be communicated with such designed dialogues that they acknowledges public correctly asking them to involve for their health safety and react with more reasonable response and not to panic.

[50]The outbreak management planning shall be done from the starting of the outbreak, the senior managers shall not ignore the agency communicator for communication planning as there are sometimes counter on non-rational notions for dealing.

The WHO[51] issues bi-annual recommendations on the composition of sessional influenza vaccine and in addition has been reviewing vaccine candidate virus[52] for A (H5N1) and other influenza subtypes with potential destructive capacity, since 2004. It is also observed that since 1999 (revised in 2005) WHO has been providing a global framework to aid countries in pandemic preparedness and response planning during the pandemic phases.[53] Repeatedly, WHO recommends member states to take up specific action plans as a part of pandemic preparation (before it happening, during its occurrence and after the pandemic) through its five components of preparedness: planning and coordination;[54] situation monitoring and assessment;[55] reducing the spread of disease;[56] continuity of health care provision[57]; and communications.[58]

According to WHO Global Status Report on non-communicable diseases 2010 (2011: vii) 57 million people died globally in 2008 and around 36 million death occurred due to non-communicable diseases[59] (NCD). The WHO believes an effective approach for reducing the impact of NCDs[60] is through improved health care, early detection and timely treatment. But the greatest effects of these risk factors fall increasingly on low- and middle-income countries, and on poorer people within all countries. So far, NCDs to a large extent are caused by four behavioral risk factors that are pervasive aspects of economic transition, rapid urbanisation and 21st-century

[51] In collaboration and consultation with WHO collaborating Centers (CCs) for influenza, National Influenza Centres, WHO H5 Reference Laboratories, and key national regulatory reference laboratories based on surveillance conducted by WHO Global Influenza Surveillance Network (GISNT). Also see the Pandemic Influenza preparedness and response: A WHO guide (2010: 24, 28, and 30).
[52] Making or providing Vaccines to the patients.
[53] There are 7 phases according to the pandemic influenza phases (2009) they are: i). Phase 1-3 predominantly animal infections; few human infections. ii). Phase 4 this sustained human to human transmission. iii). Phase 5-6 this widespread human infection. iv). Post Peak possibility of recurrent events. v). Post Pandemic disease activity at seasonable level.
[54] To provide leadership and coordination across sectors.
[55] To collect, interpret, develop, increase and continue surveillance; evaluate the characteristics of the pandemic with mitigating measures by sharing the findings to WHO and international community; and collaborate with national animal health authorities and other relevant sectors.
[56] Promote beneficial behaviour of protection through pharmaceuticals and vaccines; implement individual, societal and pharmaceutical measures collaborating with WHO and international communities as necessary; and evaluate all intervention implementation.
[57] Activate, prepare, implement, revise, rebuild, share and evaluate all contingency plans on health system; by rest and restock scale up at all levels of resources.
[58] By following the WHO pandemic outbreak communication guidelines.
[59] Comprise mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases.
[60] About one fourth of the NCD death take place before the age of 60.

lifestyles: tobacco use,[61] unhealthy diet,[62] insufficient physical activity and the harmful use of alcohol.[63]

So far, WHO[64] has a mandate under IHR (2005) to collect all the reports (including the unofficial sources) of severe international public health risks and then obtain verification of such reports from states for groundwork evaluation and when they are confirmed, the State parties are required to respond and include all available public health information within a specified time period.[65] The International Health Regulation (IHR) 2005 is an international legal instrument,[66] adopted by the World Health Assembly in 2005 through resolution WHA 58.3. Under IHR the State Parties have an obligation to inform[67] and respond to all the cases or events involving public health risk and diseases to WHO.[68]

The World Health Report is a series of reports[69] produced thematically by WHO which address how to provide policymakers, donor agencies, international organisations and others with the information they need and help them to make appropriate health policy and funding decisions. However, the report can also be accessible by universities, journalists and the public at large. It is expected that

[61] The WHO global status report 2010 (2011) states Almost 6 million people die from tobacco use each year, both from direct tobacco use and second-hand smoke But, only less than 10% of the world's population is fully protected by the demand reduction measures stated in WHO Framework Convention on Tobacco Control.

[62]Adequate consumption of fruits and vegetables and salts reduces risk of stomach cancer, cardiovascular diseases, colorectal cancer and blood pressure. The consumption of trans- fatty acids should also be reduce to have a healthy diet. The WHO global status report 2010 (2011) states at least 2.8 million people die each year as a result of being overweight or obese.

[63] In 2010 the Global Strategy to Reduce the Harmful Use of Alcohol adopted by the World Health Assembly and The WHO global status report 2010 (2011) states approximately 2.3 million die each year from the harmful use of alcohol, accounting for about 3.8% of all deaths in the world.

[64] Also see the Pandemic Influenza preparedness and response: A WHO guide (2010: 19 and 20).

[65] Also see IHR 2005.

[66] IHR which is legally binding on all the 194 State parties around the world and provides a global legal framework to prevent, control or respond public health risk that may spread between countries.

[67]The state parties have additional obligations to report to WHO evidence of serious public health risk in other States.

[68]These also include the obligation to notify WHO of all the cases of "human influenza caused by a new subtype" in their territories within 24 hours of assessment in accordance with the case definition established by WHO for this specific reasons.

[69]Bridging the gaps- 1995, Fighting disease, fostering development- 1996, Conquering suffering, enriching humanity- 1997; Life in the 21st century: a vision for all- 1998; Making a difference- 1999; Health systems: improving performance- 2000; Mental health: new understanding a new hope- 2001; Reducing risks, promoting healthy life- 2002; Shaping the future- 2003; Changing history- 2004; Make every mother and child count- 2005; Working together for health- 2006; A safer future: global public health security in the 21st century- 2007; Primary health care: Now more than ever- 2008; Health systems financing: the path to universal coverage- 2010; and Better Research for Better Health (still in progress)- 2012.

anyone, with a professional or personal interest in international health issues, will be able to read and make use of it.

The Progress with respect to challenges of achieving the right to health by WHO in accordance with the help of financial resources, through the proposed programme budget of 2012-2013 has been difficult because the financing budget of US$ 4804 million has been revised downwards to the currently proposed US$ 3959 million[70] by the Executive Board. To this point, the revisions attempt to balance the request for a realistic budget with the demands of projecting income in a situation where the largest share of financing comes from voluntary contributions. The budget further aims to match projected income more closely with WHO's implementation capacity and to align resources across the Organisation in a better manner. The right to health and WHO have a very strong bondage, as this is the only one organisation which focuses primarily on health. The other UN organisations like UNDP,[71] WB, UNICEF etc. work in collaboration with WHO and other agencies in order to provide health benefits or achievements, but the main objective of the various foundation vary according to their set-up.

4.5.2 International Labour Organisation (ILO) and the Right to Health

The ILO, established in 1919, has made a lot of special consideration with regards to the development and promotion of the right to health, for example the Maternity Protection Convention[72] 1919 of the ILO in relation to women in employment ascribed that a woman in employment, whether national/alien, irrespective of her age or marital status[73] has the right to take leave by producing a medical certificate[74] or

[70] For the base programmes it is estimated around US$ 2627 million, for special programmes and collaborative arrangements US$ 864 million and for outbreak and crises response US$ 469 million making it total US$ 3959 million. Also see Programme budget 2012-2013 (2011: 3 and 11).
[71] The UNDP is a solution-oriented, knowledge-based development organisation, supporting countries to reach their own development objectives and internationally agreed goals including Millinium development Goals (MDGs). Also see website of UNDP.
[72] The convention was adopted in 28th November 1919 and came in force on 13 June 1921. It was revised in 1952 by convention No. 103 and in 2000 by convention No. 183.
[73] See Article 2 of The Maternity Protection Convention 1919 of ILO 1919.
[74] See Article 3(b) of the Maternity Protection Convention 1919 of ILO 1919.

not be allowed to work[75] during the six weeks before her confinement[76] of giving child birth, and will receive paid maternal benefits for full and healthy maintenance of herself and her child,[77] as well as, she will receive a leave for half an hour twice a day[78] when she herself is nursing her child. This denotes that the ILO 1919 made laudable attempts to look into the situation of women and unborn/born child or infant's right to health in a suitable manner.

The Medical Examination of Young Persons (Sea) Convention[79] 1921 established compulsory medical examination of children and young person's employed provisionally at sea on any ship/boats under eighteen years of age, but exceptions were provided on the production of medical certificates with doctors signature and authorised person permit bearing witness of his/her fitness for work in those vessels where the same family members were employed,[80] though when continuing with the same service after one year interval, another medical examination or attested certificate of fitness was to be provided and this certificate of fitness exist till the end of the said voyage[81] and there is also a provision, during urgency (emergency) in the voyage the child or young person can be employed without certificate, but has to undergo the medical examination at the first port the ship arrives, this convention tries to indicate that the right to health is also a means to take preventive measures to avoid the chances of an individual falling sick, because of his/her incapability to avoid occupational diseases.

The Workmen's Compensation (Occupational Disease Convention)[82] 1925 tries to highlight that the right to health has not only been a preventive or security right but all the provisions of the necessary requirements and circumstances has lead for tort rights like in order to compensate the dependents of workmen injured or death

[75] See Article 3(a) of The Maternity Protection Convention 1919 of ILO 1919.
[76] Concluding state of pregnancy; from the onset of contractions to the birth of a child.
[77] See Article 3(c) of The Maternity Protection Convention 1919 of ILO 1919.
[78] See Article 3(d) of The Maternity Protection Convention 1919 of ILO 1919.
[79] The Convention came in force in 20th November 1922. The Convention was revised in 2006 by Maritime Labour Convention (MLC).
[80] See Article 2 of the Medical Examination of Young Persons (Sea) Convention 1921 of ILO 1919.
[81] See Article 3 of the Medical Examination of Young Persons (Sea) Convention 1921 of ILO 1919.
[82] The convention came into force on 1st April 1927. The Convention was revised in 1934 by Convention No. 42 and in 1964 by Convention No. 121.

by occupational disease[83] through the domestic law relating to compensation for industrial accidents.[84] The Equality of Treatment (Accident Compensation) Convention 1925[85] ensures that there won't be any discrimination based on nationality[86] for the compensation of treatment extended to the injured workers by industrial accidents and Article 3 of the convention demands the formation of a system to compensate, through insurance or other arrangements.

The Sickness Insurance (Industry) Convention[87] 1927 in its Article 1 talks about the compulsory sickness insurance system and Article 7 correctly points that the insured persons and their employers shall share the burden of the financial resources of the sickness insurance system. The Sickness Insurance (Agriculture) Convention[88] 1927 in its Article 6(1) asserts that the self- governing institution shall administer sickness insurance with administrative and financial supervision by a competent authority and the insured persons and the employers shall bear the financial resources for the sickness insurance system[89] and it is not to be viewed as a profit making sphere thus, private institutions are to be approved by competent public authority.

The ILO declares that the developmental phase of the right to health started in the ILO long time back. Where, the insurance concept had also taken birth as a means to rescue individuals from financial constrains during need. The ILO has also made many other developments, yet these conventions have given direction towards the achievement of the right to health, the best example that can be put forth is the streamlining of objectives concerning occupational health practices that were originally defined in 1950 by the Joint ILO/WHO Committee on Occupational Health stated that:

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[83]See Article 2 or the schedule of the Workmen's Compensation (Occupational Diseases) Convention1925. They are those diseases and poisonings produced by the substances by lead, by mercury, and Anthrax infection (A highly infectious animal disease especially of cattle and sheep, it can be transmitted to people).

[84] See Article 1 of the Workmen's Compensation (Occupational Diseases) Convention1925.

[85] Came in force on 08th September 1926 in concern with Equality of Treatment for National and Foreign Workers as regards Workmen's Compensation for Accidents.

[86] See Article 1(2) of the Equality of Treatment (Accident Compensation) Convention 1925.

[87] Came in force on 15th September 1928. The Convention was revised in 1969 by Convention No. 130. It is in concern with Sickness Insurance for Workers in Industry and Commerce and Domestic Servants.

[88] Came in force on 15 September 1928. The Convention was revised in 1969 by Convention No. 130. Is a sickness Insurance for agricultural workers.

[89]See Article 7(1) of The Sickness Insurance (Agriculture) Convention 1927.

> "Occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarise: the adaptation of work to man and of each man to his job".[90]

The ILO tries to describe that the right to health mandates facilities to the all spheres, public and private, still there are hazards taking place in the labour industries which indicates that the ILO bears the responsibility to evolve stronger mechanisms to address the health sector incorporating incidences and cases that occur in various industries whether private or public.

4.5.3 Food and Agriculture Organisation (FAO) and the Right to Health

The fact sheet of 2010 No.34 in the right to adequate food points out that there is a component shared between the right to health and the right to food and that is nutrition[91], In contribution by the World Declaration on Nutrition, International Conference on Nutrition (ICN), Rome 1992 in defining malnutrition rightly assumes that consuming food also needs healthy body in order to make the digestive system function correctly:

> "Malnutrition is the lack of adequate food utilisation which, in this context[92], is the proper digestion and absorption of nutrients in food by the human body and requires adequate diet, water sanitation, health services, and health education".

The Objective 2.4 (d) of Rome declaration on World Food Security 1996 lays emphasis on nutrition intake, sanitation, and health education, home economics,

[90] Also see Rantanen. Jorma, and Fedotov. Igor A, (1995: 5) "Standards, principles and approaches in occupational health services"

[91] A pregnant or breastfeeding woman cannot be denied from the access of nutritious food, the chances of getting malnourished is high even if she receives pre- and post-natal care. And same goes with a child who is suffering from diarrhoeal disease who has an access to food but denied to medical treatment, he/she cannot enjoy an adequate nutritional status.

[92] Every country has vulnerable population, disadvantage individuals, households and group who cannot meet their own needs. As 70% of women are poor and poverty hinders in access to good quality and quantity of food.

environmental protection, food supply and health related functions. The right to health in FAO is limited to adequate nutrition and safe food the constraint towards the purpose of health right is how much the individual is taking nutrients.

4.6 Case-Laws on Right to Health

4.6.1 *Kirk v. Board of Health*[93] *Supreme Court of South Carolina 83 S.C. 372; 65 S.E 387*[94] *(1909)*

Facts of the case: In this case Mary Kirk a women while working as a missionary in Brazil got infected with anaesthetic leprosy[95] and to prevent this disease from infecting others, the Local Board of Health (Aiken) ordered for her isolation as Miss Krik was dangerous because she use to teach Sunday Schools, attended Church services, mingled with people in social life in Aiken city. So, based on the grounds of section 1099 of Civil Code which provides: "the said board of health has power and it is their duty to make and enforce all needful rules and regulations to prevent the introduction and spread of infectious or contagious diseases by the regulation of intercourse with infected places, by the arrest, separation, and treatment of infected persons, and persons who shall have been exposed to any contagious or infectious diseases. The board with the consent of the town or city council has power to establish one or more hospitals and to make provisions and regulations for the management of the same during the prevalence of any contagious or infectious diseases within the town or city". Further, the constitutional law governing health regulation also states that the isolation of infected person does not violate the right to enjoyment of liberty and property as the right does not allow injuring others by liberty or property[96]. The constitution also states that the health board must inquire and take action promptly when public health is endangered. But Miss Krik who is advanced in age claimed that

[93] Also see Lawrence, O. Gostin. (2010) Public health and ethics: A reader, chapter 7- public health and protection of individual rights: 388-394. University of California Press.
[94] Decided on 19th August 1909. Supreme Court of South Carolina.
[95] It is considered that anaesthetic leprosy is slightly contagious, as for its communicable process touching, or personal association is required.
[96] The personal liberty and property restriction only takes place when reasonable and necessary public health danger appears. The Court determines whether there is requirement of following such restriction.

the place where is about to be kept is actually a pest house, coarse and comfortless which is used for imprisoning Negros having small pox and other dangerous infection, the hospital also had a horrible smell which came from the city dumping located nearby the hospital.

The Supreme Court affirmed that States have the right, under their police powers, to quarantine and isolate individuals from the community who have been in contact with a contagious disease. Under Kirk v. Wyanman, it was decided that the Board of health of each state should decide who should be quarantined under the threat of an infectious disease. However, the Supreme Court makes it clear that if the quarantine is involuntary, people have the right to appeal the Board of Health's decision to the court. This provision was added because it was understood that the case of Kirk v. Wyman was an unusual case and that, under certain circumstances, the right of the individual is not subversive to the rights of the community as a whole. The case of Kirk v. Wyman dictates that, at certain times, the rights of individuals must be undermined for the protection of the overall community.

4.6.2 *Minister of Health v. Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC)*[97]

Facts of the case: In this case the Treatment Action Campaign[98] (TAC), in August 2001, filed a suit in Pretoria High Court stating that the Government policy was unconstitutional and failed to respect human rights obligation[99] by not distributing the nevirapine[100] drug in all government hospitals for pregnant women. Because, the South African Government had authorised only two research sites to distribute nevirapine, as a national programme to reduce risk of mother- to- child transmition of HIV.

[97] Also see WHO fact sheet No. 31: the right to Health.
[98] TAC is an NGO: a network of organisations and individuals campaign for equitable and affordable access to HIV/AIDS treatment.
[99] The South African Constitution recognises the right to access public health care services and for children the right to special protection.
[100] A non-nucleoside reverse transcriptase inhibitor (trade name Viramune) used to treat AIDS and HIV.

The High Court in December 2001, decided in favour of TAC and later the Constitutional Court (After Appeal) in 2002 held that the Government should remove restrictions on the availability of the nevirapine at public hospitals and clinics that are not research sites and provide access to health services to combat with mother- to-child transmission of HIV, by implementing comprehensive and coordinated programmes in realising the rights to health for pregnant women. It has firmly established that social mobilisation by people can also creates effect in achieving the right where the Government is not able to sanction the obliged rights to its people. But this initiative, led by NGO also helped the social mobilisation for ensuring equitable access to HIV/ AIDS Treatment and making availability of medicines to most needed.

4.6.3 *Mouisel v. France Application No. 67263/01*[101]*. France.*

Facts of the case: On 12th June 1996,[102] a French national Jean Mouisel,[103] was sentenced for fifteen years. A medical certificate[104] dated 8th January 1999 stated that the applicant was suffering from B-cell chronic lymphatic[105] leukaemia[106] with some evidence of tumor. When his condition deteriorated,[107] He was taken for chemotherapy[108] sessions during day time by putting chains to the hospital and while entering the guards use to show him their aggressive behaviour as well as, when the

[101] The European Court of Human Rights (application number 67263/010) held that there had been a violation of the prohibition of inhuman or degrading treatment in the case of Mouisel v. France. In the Court's view , the national authorities failed to have sufficient regard to the applicant's condition, who suffered from chronic leukaemia. The Court held that his continued detention amounted to inhuman and degrading treatment. It awarded the applicant 15,000 euros forn non- pecuniary damage.

[102] The Haute- Garonne Assize Court sentenced the applicant to fifteen years' imprisonment for armed robbery carried out as part of a gang, kidnapping and fraud. He was detained in Lannemezan Prison (department of Hautes- Pyrenees).

[103] Jean Mouisel was born on 1948 and was from Fougaron (France).

[104] A doctor from the Outpatient Consultation and Treatment Unit (unite de consultation et de soins ambulatoires- "the UCSA") at Lannemezan Prison issued the medical certificate on the request of the patient and handed him in connection with an application for parole (a conditional release from imprisonment that entitles the person to serve the remainder of the sentence outside the prison as long as the terms of release are complied with) on medical grounds.

[105] Lymphatic means when it is relating to or produced by lymph. A lymph here means a thin coagulable (thick) fluid (similar to plasma but) containing white blood cells (lymphocytes) and chyle or is conveyed to the blood stream by lymphatic vessels.

[106] Malignant neoplasm of blood-forming tissues or characterised by abnormal proliferation of leukocytes or one of the four major types of cancer (cancer of blood).

[107] On 12th May 2000 the UCSA doctor drew up a further medical certificate stating that the patient was digonised in November 1998 with chronic lymphocytic leukaemia and currently transforming into lymphoma (one of the four major types of cancer (cancer of blood)) and he requires cancer treatment in the form of chemotherapy every three weeks.

[108] The use of chemical agents to treat or control disease.

session use to start his feet and one of his wrists were chained to the bed. Due to such humiliation he decided to stop his medical treatment in June 2000. So, He filed a complaint on the violation of Article 3[109] and 41 dealing on inhuman treatment or punishment/degrading treatment or punishment. There was even a medical report[110] drawn on 28th June 2000 which concluded the applicant should be treated in specialised clinic. On 19th July 2000 he was transferred as necessity to Muret Prison so that he could be near Toulouse Hospital. On 22nd March 2001 he was released on licence subject to an obligation to undergo his treatment or care.

The Court held that the period of first medical diagnosing of the applicants condition should be taken into consideration. The court also noted that the prisoners state of health, age or serious physical disability were factors to be taken into account in determining how prisoners sentenced should be serve.[111] Consequently, the Court observed that the prisons authoritative have failed to take special measures on the prisoner's health condition,[112] as his illness deteriorated more. The Court found that the treatment on transfers were offensive to the recommendations of the European Committee for the prevention of Torture regarding the conditions in which prisoners are transferred and medically examined and under Article 41 of the Convention, the Court awarded the applicant 15,000 Euros (EUR) for non-pecuniary damage.

4.7 Summation

This chapter dealt with the provisions of availability, accessibility, acceptability and quality of health as provided by article 12 of the General Comment No. 14. These provisions are not mandatory but recommendatory to the States parties of the Covenant on Economic, Social and Cultural Rights. The right to health embeds essential elements of discrimination, consent, disability, rights of patients, and access

[109] Article. 3 required States to protect the physical integrity of persons who had been deprived of their liberty, notably by providing them with any necessary medical assistance.
[110] A medical application in order to determine whether the applicant's state of health was compatible with his continued detention.
[111] The Law of 15th June 2000, prisons could be released on licence when they needed to receive treatment and by the law of 4th March 2002 on the rights of the sick, persons' sentenced could be suspended if they are critically ill or suffering from chronic condition that was incompatible with their continued detention.
[112] The prisoner's continued detention from June 2000 and he had suffered acute hardship in prison while suffering from cancer.

to medicines. These essential elements make the factual and legal acceptance of the right to health with human rights. The international legal instrument have tried to acknowledged the presence of these essential elements for health rights in there Articles or sections of their legal documents. Still, these instruments are not able to convey the rights for eradicating the health equality and accessibility. The marginalised populations have been the most vulnerable population, who are the burden of societal arrangements, particularly with mental, physical, social, sexual, and reproductive health risks. Since, there has been observe a separate category of vulnerable people by WHO, it makes clearer the observation that, how discrimination or stigmatisation along with the denial of access to health care and facilities to the weaker sections and vulnerable people or the resource poor persons have made their condition more miserable. When he/she is denied with their right to health, the experience they face is in reality difficult and painful to narrate.

However, the cases mentioned above tries to narrate the vulnerability of those individuals who face discrimination and are not provided the right to health. This proves that such unpredicted conditions and situations makes things more complicated to understand. Courts have tried to deal with their conditions, but these measures have only mitigated damages and not provided satisfactory legal obligations. The Health Rights can only be possible when the responsibility of health is taken by individuals, community, the State and International community because the joint efforts of whole social fabric will only provide the achievement of the right to health possible in reality. Moreover, the WHO which is the only organisation functioning primarily focusing on health, has no binding right on other countries, still it has always tried to contribute to the progress of rights related to health and their accessibility. The ILO, is an organisation whose mention is of immense importance due to the requirements of socio-economic scenario, where no individual can work, having no health facilities during his/her working time, as the right to health in today's cooperate world requires the flow of occupational health rights and facilities. The FAO is also one of the important organisations. As FAO only made the possibility of providing the realisation of the achievements of health facilities, by acknowledging what humans have to consume to be healthy and to how much quantity. The nutrients if not taken in sufficient amount can also affect the health of an individual.

CHAPTER-V

CONCLUSION

The undeniable attainment of the Right to Health is clearly observed in international and national legal order. The right to health is comprised of freedom and entitlements. The freedom includes the right to control one's health including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health.

The Right to Health under international law is segregated with many International Human Rights Instruments and Specialised Organisations, having different approaches on Right to Health. The different international bodies made the definition of Right to Health more complex and ambiguous, as all different Conventions deals with different kinds of health issues. However, the iniquitous international order is responsible for the widespread inequalities and poverty, for preventing the realisation of the right to health. If systematic reporting is done by the State Parties to the responsible International Bodies with the compliance of the human rights obligation then the implementation of the right to health by the monitoring bodies will make the realisation of the right to health to its fullest. So far, rights are those claims that are necessary in order to perform duties, expected by members of a peaceable society.

Mainly, this includes the achievement of minimally disabled social participation. One cannot perform the roles of an active citizen, or of a person fulfilling their personal ambitions to the best of their ability, if one cannot be made healthy (if possible) when one is disabled. Consequently, execution of normal duties expected of a member of society implies an obligation on the part of society to provide its members with a reasonable level of health care. There must be a right to health care because society has duty to provide for the health of its members, to the extent that social resources are available. (Martin Rothblatt 2004: 106).

The right to health can only be achieved when the improving of the determining factors like the cultural practices, economic differences, environmental and social political conditions of health status are understood in shaping the right to health. The right to health is an economic, social and cultural right as the Convention on Economic Social and Cultural Rights 1966 furnishes with specific instrument dealing more rationally to the elements of the right to health by harmonising demands of Government initiative to create better condition for people rather than restraining their rights in providing health promotion and requirements of human rights.

The study attempts to trace the background of the health right with its development.

It further, attempts to survey the international legal instrument on right to health and comes to an understanding that the right to health is embedded in all major human rights conventions, but the right to health is dealt exclusively in the ICESCR 1966 Articles 12(1) and 12(2). However the Covenant of ICCPR and ICESCR including UDHR are not legally binding, under international law. Moreover, all Human Rights Treaty Monitoring Bodies' observation and concluding remarks are recommendatory in nature. Thus, it fully depends on the States willingness to implement the right to life and the right to health. On the other hand, the other Human rights Conventions also dealt with the right to health partially but not exclusively.

States have legal obligation to implement rights recognised in those treaties which the State Parties have ratified. So in order to formulate the rights as a legal obligation on the country, the state parties to these treaties accept to submit regular reports. The initial submission of report is made in one year (two years for CRC) after ratifying the treaty and later in compliance with the provisions arrangements set therein (generally in four or five years) in addition to this the treaty bodies may also receive Complaints from the Non-Governmental Organisations (NGOs), UN agencies, other Inter Governmental Organisation (IGO), Academic Institution and Press on the conduct of the Countries, based on this dialogue and commitments, the Committee publishes its concern and recommendations, referred as "Concluding Observations". So far, there is no Complaint made in HR bodies. Though there is Complaint Mechanism. It is hard to find any complaint registered before these Committees. In

Regional Level, the African Region not only faces health problems but it also deals with major ethnical and traditional or religious practices, having genocides and violence with low literacy rates, which is comparatively different in America (Latin and Afro-American) and Europe (Settled- Migrants) region. At the UN agencies level the WHO, UNICEF and UNAIDS together work for all health issues, where UNICEF looks more into child health and UNAIDS in the patient of HIV/AIDS. So far, WHO is the only full-fledged functionary on health related issues, dealing on infection, diseases, problems of old-age person, children, women or pregnant women with pre and post natal implications or issues, migrants, refugee, person in prison, and so on.

Further, on the marginalised populations who have been the most vulnerable population, considered as the burden of societal arrangements, particularly with mental, physical, social, sexual, and reproductive health risks. The discrimination or stigmatisation faced by the vulnerable sections along with the denial of access to health care and facilities to the weaker sections or the resource poor persons make their condition more miserable. The Health Rights is only possible when the responsibility of health is taken by Individuals, Community, the State and International Community because the joint efforts of whole social fabric will only provide the achievement of the right to health possible in reality. The International Organisations have also contributed in achieving the realisation of the right to health, through the mechanism of WHO, ILO and FAO. As, WHO, is the only health organisation, that full-fledged functions to bring progress in health rights and their accessibility. The ILO, is an organisation which provides immense importance to the requirements of socio-economic scenario with occupational health rights, safety and facilities. The FAO is one of the important organisation that provides the realisation of health facilities through health requirements of right amount of nutrient consumption.

Moreover, the Right to Health is a Human Right. Recognised and protected by the International Covenant on Economic, Social and Cultural Rights. It also has been recognised in the jurisprudence of a number of national courts. Further, the Committee on Economic, Social Council and Cultural Rights during the Rio+20 Conference on 30th April- 18th May 2012 made a Statement on the Right to Health that there is need to protect the natural habitat and the natural resources by sustainable

use for the enjoyment of the Right to Health (under art. 12 of ICESCR) elements as in access to safe and potable water and the prevention of water degradation and pollution that affect the right to health. Furthermore, the sanitation situation and the collection and disposal of hazardous waste not only cause implications for the environment but can also potentially cause epidemics and waterborne diseases and thus negatively affect the right to health.

From the human rights perspective, the basic question arises whether the government is taking steps to make medication accessible, physically and economically, and to make information relating to medication accessible as well to the public? The human rights frame work balances the cost-effectiveness concerns with other priorities and thus, the state has pivotal role to play both in ensuring basic health care services and in regulating inequalities of the market.

Human Rights sets out an alternative paradigm to models based entirely on charity or cost-effectiveness, which among other things, demands meaningful popular consultations and participation in decisions affecting access to medication, including the adoption of trade and regimes that could affect accessibility. In addition to underscoring principles of participation, Non-Discrimination, and concern for Marginalised and Vulnerable groups, a Human Rights framework with respect to Access to Medications is also grounded in specific norms under International Law. Moreover, States needs to consider the elaboration of Competition Laws that prevent the abuses of IPRs that lead to violations of the right to health in particular the setting of high prices essential drugs. Member states of WHO should implement those provisions in national legislations which safe guard the access the essential drugs as a component of the right to health as well as other human rights. Developed countries should establish clear incentives to promote technology transfer and the supply of affordable drugs to developing countries.

The concept of Right Health and its transformation as Human Right into reality and overcoming the obstacles to its realisation the following measures needs to be adopted: (i) Improving knowledge an understanding of health; and (ii) Creating social,

economic, and environmental conditions that are conducive to health. These two obstacles can become a reality when there is high lighten awareness made on health matters among Policy Makers, Politicians, Economic Planners, and Public alike, and when this awareness is transformed into policies legislation and favorable allocations of resources for health. For it, a threefold strategy may be adopted, i.e. (i) Advocacy for Health; (ii) Social Support; and (iii) Empowerment of People. These strategies together constitutes a power instruments for promoting healthy life styles and creating conditions contusive to health, though each strategy has its own distinctive characteristics and primary focus.

The Implementation of Right to Health requires affirmative of action on the part of Governments, and implicates interventions in the Internal Domestic Affairs of Nations. Further, having diverse cultures and different economic levels, by different Nations of the World, it is hard to envisage a mandate that would help to implement Right to Health. But, in order to implement appropriate realistic implementation by all the Nations Scholars have proposed following three major approaches.

Firstly, defining universal outcome measures for measuring the compliance with the core state obligations of the human rights to health. It would also indicate where countries need to concentrate on efforts to meet their obligations under the international human rights to health. The UN and WHO already appreciate the possibilities of reported data on outcome measures in Monitoring Compliance of States with International Human Rights Obligations.

Secondly, Systematic Reporting to responsible international bodies for Monitoring progress on Implementation and Compliance with International Human Rights Obligations. If a Country meets these universal outcomes measures specified in Systematic Reporting System. Then the responsible, International Bodies as well as Domestic Constituencies will assume that Implementation and Compliance have occurred. This approach would mitigate the need for international bodies delve deeply into the internal affairs of the nations to assure Implementation and Compliance. For-Example: The WHO has begun reporting countries health statistics on a comparative basis, such as in ‘World Health Report -2000’ the WHO published its first comparative analysis of the world’s health systems.

Thirdly, Civil Rights violations need to be high lightened, such as Discrimination against protective groups that inhibit access to health services. Here the special needs of the vulnerable and higher risk groups who are least able, for geographical, political, social, or financial reasons has to be paid attention and to be given high priority. It is necessary to identify systematically those who are at highest risk, for providing continuing care to them and to eliminate factors contributing ill health.

Health is the main functioning component for survival of human beings, whether it is disease resistance, proper balance diet, nutrition intake, free from mental stress or any physical disability. The efforts of being fit since the day of human existence in mothers' womb starts there and then, where an individual inside mother needs the right to health and vis-a vis the mother who is carrying the baby inside her womb. The concept of the Right to Health under International Law seems relatively dense. Still, there is lack of understanding in its accurate meaning. The definitions provided under the International Treaties are still struggling with its true sense of achievements, the Right to Health has always been accepted as a component of the Right to Life, where the significance of the Right to Health has been observed as minimal requirement which is infuriating the essence of health rights. But, the prevalence in achieving the purpose of the Right to Health needs a special understanding and care. At present scenario, the Right to Health has been understood as the Socio, Economic Right which needs to be identified with the requirements of economical setup, social and political demands depending on the requirement of the populations for health care and health services.

The lacuna what has been drawn, in finding out the main aim of study has been very vital in confronting the acceptance that still, there is no proper mechanism or Court where the relevance of health suffering, pain, agony and economic imbalance can be revealed, in contributing the aspects of reality what international law has been confronting towards the right to health. As, "The Human existence has always been marked by pain, limitation, disability, disease, suffering, and death. All these facts of life and of death have provided ample grounds for characterising much on human conditions as unfortunate. A core philosophical question what arises is whether the

circumstances are in addition unfair or unjust in the sense of justifying claims on the resources, time, and abilities of others.

The realisation of the right to health in unbalanced economy of the world bearing more burden of population and having one third global disease in poor countries, make things more complicated for the implementation of effective health policy. As the lack of economic source, education, access to basic life resources such as food, water and sanitation, as well as insufficiency of control over the reproductive process directly accounts causing poverty to breed in ill health and ill health to breed in poverty, which not only hampers the economic, social development but also contributes in unsustainable resource depletion. The health promotion falls within all the human rights states and others have a legal obligation on it as the right to health is not just an optional or extra, incidental or marginal right. But, it is something that all the nations are required to do. As Lawrence O. Gostin and Emily A. Mok (2009: 16) have corrected argued that the international community with the partnership of the host countries should invest in health arrangements in order to provide the basic survival requirements and guarantee efficient and well-functioning health arrangements in poor countries.

In the light of above facts and discussion, the present study makes few recommendations for better implementation of the right to health.

Firstly, the existing human rights regime is complex and ambiguous to understand and locate the right to health. Moreover, the segregated obligations on right to health under various international conventions and orgnisations created enormous confusion in realisation of right to health. Therefore, there is an urgent need to adopt an international convention for the protection and promotion of the health for its proper understanding and implementation.

Secondly, there is urgent requirement of making the implementation of the right to health to its fullest form by providing accessibility, affordability, availably and quality of health at all domestic levels by the States with the help of international community.

Thirdly, the UN should take initiative in effective performance for the International Health Fund (the Global Health Fund to fight AIDS, Tuberculosis and

Malaria) through mobilising more voluntarily and obligatory funds by member states of the UN.

Fourthly, Systematic reporting on implementation of all the rights by the State Parties should be provided efficiently, to the responsible International Bodies for properly monitoring effectiveness of the right to health.

Fifthly, considering the local realities the priorities and approaches for health solution should be personalised and contextualised, thus privatisation of health care should not be done. *Finally,* it is time to realise that the Right to Health is a global issue, where collective responsibility and collective commitments have to be made by Fighting through Solidarity and with Right Movement.

In conclusion, it is time to realize that health has become global issue it should be considered as an essential component of the continuing global process that is reshaping interaction between countries in terms of world trade, services, foreign investments and capital markets. A wonderful opportunity now exists to build a new international partnership for health based on social justice, equity and solidarity, which the world in 21st century will so urgently need. Therefore, the entire World Community, all Governments, and the Orgnisations should unite to achieve a common goal of Humanity “Health for All” without any Discrimination.

APPENDIX- 1

Declaration of Alma-Ata 1978

The International Conference on Primary Health Care[1], meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming

[1] International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and

other international organisations, as well as multilateral and bilateral agencies, nongovernmental organisations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

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APPENDIX- 2

Health-for-all policy for the twenty-first century 1998[1]

The Fifty-first World Health Assembly,

Recalling resolution WHA48.16;

Recognising the report "Health-for-all in the twenty-first century" (A51/5) as a framework for the development of future policy,

ADOPTS in the sense of Article 23 of the Constitution the World Health Declaration annexed to the present resolution.

Annex

WORLD HEALTH DECLARATION

I

We, the Member States of the World Health Organisation (WHO), reaffirm our commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health.

II

We recognise that the improvement of the health and well-being of people is the ultimate aim of social and economic development. We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies. We emphasise the importance of reducing social and economic inequities in improving the health of the whole population. Therefore, it is imperative to pay the greatest attention to those most in need, burdened by ill-health, receiving inadequate services for health or affected by poverty. We reaffirm our will to promote health by addressing the basic determinants and prerequisites for health. We acknowledge that changes in the world health situation require that we give effect to the "Health-for- All Policy for the twenty-first century" through relevant regional and national policies and strategies.

III

We recommit ourselves to strengthening, adapting and reforming, as appropriate, our health systems, including essential public health functions and services, in order to ensure universal

[1] Fifty-First World Health Assembly, Agenda Item 19, WHA 51.7, 16 May 1998.

access to health services that are based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future. We intend to ensure the availability of the essentials of primary health care as defined in the Declaration of Alma-Ata[2] and developed in the new policy. We will continue to develop health systems to respond to the current and anticipated health conditions, socioeconomic circumstances and needs of the people, communities and countries concerned, through appropriately managed public and private actions and investments for health.

IV

We recognise that in working towards health for all, all nations, communities, families and individuals are interdependent. As a community of nations, we will act together to meet common threats to health and to promote universal well-being.

V

We, the Member States of the World Health Organisation, hereby resolve to promote and support the rights and principles, action and responsibilities enunciated in this Declaration through concerted action, full participation and partnership, calling on all peoples and institutions to share the vision of health for all in the twenty-first century, and to endeavour in common to realise it.

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[2] Adopted at the International Conference on Primary Health Care, 1 Alma-Ata, 6-12 September 1978, and endorsed by the Thirty-second World Health Assembly in resolution WHA32.30 (May 1979).

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