

# HAKI ZETU

## ESC rights in Practice

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## The Right to Health

*Haki Zetu* is Swahili for Our Rights

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The programme aims to contribute to:

- The growth of human rights activism in Africa, with an emphasis on making human rights work in and for rural communities; and
- Innovation of strategies and methods to make a meaningful contribution to the promotion, protection, respect and fulfilment of human rights in Africa.

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Finally, Rutgers WPF, a Dutch knowledge centre on sexual and reproductive health and rights (SRHR), contributed to this handbook, providing additional content and suggesting revisions for appropriate attention to SRHR, gender and youth issues. The handbook was finalised by Wim de Regt, currently responsible for Amnesty International's Haki Zetu project, and Gillian Nevins.

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The development and production of the Haki Zetu handbook series was managed by Peter van der Horst (up to October 2010) and subsequently by Wim de Regt, both of Amnesty International Netherlands' Special Programme on Africa.

The *Haki Zetu* handbook series is developed by Amnesty International in partnership with others. It is an educational tool and not an Amnesty International policy text. Facts and case examples are directly taken from quoted sources and not corroborated by Amnesty International.

	<b>List of figures, boxes, tables and checklists</b>	<b>8</b>
<hr/>		
	<b>Introduction</b>	<b>10</b>
<hr/>		
	<b>1 Understanding the right to health</b>	<b>13</b>
<hr/>		
1.1	The current situation of the right to health in Africa	13
1.2	What is the “right to health”?	15
1.2.1	The right to health: what it is and what it is not	15
1.2.2	Linking the right to health to other rights	16
1.2.3	Main violations of the right to health	16
1.3	Health systems and the right to health	18
1.3.1	The basics about health systems and the right to health	18
1.3.2	More in-depth about health systems	20
1.4	The right to health facilities, goods and services	24
1.4.1	The basics about health facilities, goods and services	24
1.4.2	More in-depth about health facilities, goods and services and the underlying determinants of health	26
1.5	The right to sexual and reproductive health	26
1.5.1	The basics about sexual and reproductive health and rights	26
1.5.2	More in-depth about sexual and reproductive health including family planning	28
1.5.3	The basics about maternal and child health	30
1.5.4	More in-depth about maternal mortality	31
1.6	The right to mental health	33
1.6.1	The basics about mental health	33
1.6.2	More in-depth about mental health	34
1.7	The right to healthy natural and workplace environments	35
1.7.1	The basics about healthy natural and workplace environments	35
1.7.2	More in-depth about healthy natural and workplace environments	36
1.8	The right to prevention, treatment and control of diseases	37
1.8.1	The basics about prevention, treatment and control of diseases	37
1.8.2	More in-depth about prevention, treatment and control of diseases	37
1.8.3	Neglected diseases and the right to health	38

- 1.8.4 Access to essential medicines (drugs) 39
- 1.8.5 International dimensions of health 40
- 1.8.6 HIV/AIDS and the right to health 41
- 1.9 Marginalised groups and the right to health 43
  - 1.9.1 Women 44
  - 1.9.2 Infants, children and adolescents 45
  - 1.9.3 Older persons 46
  - 1.9.4 Persons with physical and mental disabilities 46
  - 1.9.5 Indigenous Peoples 47
  - 1.9.6 Migrants 47
  - 1.9.7 Prisoners and others living in institutions 47

## **2 Preparing to take action 48**

---

- 2.1 Identifying government obligations 49
  - 2.1.1 Obligation to take steps 49
  - 2.1.2 Obligation to respect 50
  - 2.1.3 Obligation to protect 50
  - 2.1.4 Obligation to fulfil 51
  - 2.1.5 Core obligations 51
  - 2.1.6 Our obligations to protect our own health 51
  - 2.1.7 The right to health in national and local legislation and policies 52
  - 2.1.8 Where to find laws and policies 53
- 2.2 Enforcing the right to health at the domestic level 53
- 2.3 Regional human rights law and accountability institutions 55
  - 2.3.1 The role of the African Commission 55
- 2.4 The role of non-State actors 56
- 2.5 Case study: Identifying violations of the right to health 57
- 2.6 Identifying and planning strategies for action 59

## **3 Actions to realise the right to health 60**

---

- 3.1 Before taking action 60
- 3.2 Raising awareness of the right to the highest attainable standard of health 61
  - 3.2.1 Raising awareness among the community 61
  - 3.2.2 Raising awareness among the general public 62
  - 3.2.3 Raising awareness among health officials 62
- 3.3 Monitoring the right to health 64
  - 3.3.1 Monitoring access to health care facilities, goods and services and underlying determinants of health 64

CHECKLIST 1. Monitoring health facilities, goods and services	66
3.3.2 Monitoring underlying determinants of health	69
CHECKLIST 2. Monitoring underlying determinants of health	70
3.4. Actions to improve access to sexual and reproductive health	72
3.4.1 Improving access to sexual and reproductive health for youth	72
3.4.2 Tackling harmful traditional practices	72
3.4.3 Monitoring maternal and infant mortality	73
3.4.4 Raising awareness of maternal, sexual and reproductive health	75
3.4.5 Preventing and reducing maternal and infant mortality	76
3.5 Actions to address discrimination against people with mental illness	77
3.6 Actions to promote healthy workplace and natural environments	78
3.6.1 Health survey of workplace environments	78
3.6.2 Mapping health hazards in the natural environment and taking action	78
3.7 Actions to increase prevention, treatment and control of diseases	79
3.7.1 Access to immunisation against diseases	79
3.7.2 Monitoring access to health-related information and education	80
3.7.3 Monitoring access to medicines	81
3.8 Actions to increase the right to health of marginalised groups	82
3.8.1 Monitoring access to health care by marginalised groups	82
3.9 Other actions to realise the right to health	85
3.9.1 Right to health indicators	85
3.9.2 Right to health impact assessments	87
3.9.3 Analysing policies and budgets	87
3.9.4 Building alliances, mobilising communities and lobbying the government	87
3.9.5 Reporting to the CESCR and the African Commission	87
3.9.6 The international and regional arenas	88



---

**Acronyms 89**

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---

**Glossary 90**

---



---

**Endnotes 100**

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---

**Appendices 102**

---

1:	International and regional human rights laws and standards	103
2:	Sources and resources on the right to health	113
3:	NGOs and INGOs	116
4:	The Millennium Development Goals and their progress in Africa	121
5:	Template for making your own checklist	123



## List of figures, boxes, tables and checklists



### Boxes

---

- Box 1: Resources allocated by African governments to health care 15
- Box 2: Using technology to improve health care delivery 23
- Box 3: The three delays 31
- Box 4: Raising awareness about mental health 34
- Box 5: Climate change and health 35
- Box 6: Toxic waste dumping leads to serious health problems in Ivory Coast 36
- Box 7: Stigma and discrimination 38
- Box 8: Harmful practices 40
- Box 9: Traditional medicines and HIV/AIDS 42
- Box 10: Birth registration and health 46
- Box 11: People's Health Movement and Right to Health Campaigns in Benin 48
- Box 12: The Africa Health Strategy (2007-2015) 49
- Box 13: Medical councils 50
- Box 14: The right to health in some African constitutions 52
- Box 15: The role of courts 54
- Box 16: The Ogoni case 55
- Box 17: The African Commission and the right to health 56
- Box 18: Raising awareness about HIV and AIDS in Nigeria 63
- Box 19: Health Rights of Women Assessment Instrument (HeRWAI) 64
- Box 20: How to use checklists 65
- Box 21: Assessing domestic violence policies 73
- Box 22: Example of an African NGO working on climate change 79
- Box 23: Fathers take more responsibility for their children's health 80
- Box 24: An African coalition working on the right to health 81



### Figures

---

- Figure 1: The poverty trap 14
- Figure 2: Determinants of the right to health 17
- Figure 3: The WHO's six essential building blocks of a health system 19



## Tables

---

Table 1: Topics for awareness-raising 63

Table 2: Monitoring access to emergency obstetric (childbirth) facilities 74

Table 3: Monitoring access to health care by indigenous peoples 83

Table 4: Developing right to health indicators 86

Table 5: The right to health 105



## Checklists

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Checklist 1. Monitoring health facilities, goods and services 66

Checklist 2. Monitoring underlying determinants of health 70

The right to the highest attainable standard of health is a fundamental human right. Good health is not only the absence of disease or illness, it is “a state of complete physical, mental and social well-being”.<sup>1</sup> Having good health allows us to enjoy other rights such as the rights to work, to an education and to participate in community life. Being healthy allows us to live a more dignified life and play a full part in society. To enjoy good health we need access to medical care and health-related information. Just as importantly, we need access to things that keep us healthy including safe drinking water and sanitation, sufficient and healthy food, adequate housing and proper education. These are called the “underlying determinants of health” because they determine or influence people’s health. The Haki Zetu handbook series contains separate booklets on the right to food, the right to water and sanitation, and the right to housing.

Terms with a ‘>’ are defined in the Glossary.

Over the last few decades remarkable progress has been made to improve health and combat disease. However, in many countries, only the better off enjoy the benefits of well equipped and well functioning health services. Those living in poverty are much less able to live a healthy life, due to a vicious circle of insufficient food, higher vulnerability to diseases (such as > diarrhoea, > malaria and HIV/AIDS), low access to medical care and fewer opportunities to earn a living and to proper education. The > burden of ill health falls on whole families and passes down the generations.

Millions of people in Africa and around the world do not receive health care. They may lack information about health care; there may be no health facilities within easy reach; or the facilities may lack adequate medical supplies and equipment. In other words, people are suffering or dying of medical conditions which, if services were improved, could have been prevented or treated.

Women and children are disproportionately affected by poverty. Besides, women are disempowered by unequal > gender relations. They also face higher health risks related to pregnancies and child bearing. Young children under five are more vulnerable to diseases and many die, often due to preventable diseases like diarrhoea, malnourishment and lack of adequate medical care.

Putting the right to health into practice would allow everyone, regardless of who they are or what health problems they have, to be able to receive help and treatment. Better health would also benefit the economy and society as a whole.

It is the obligation of States to set up and take care of a well functioning health system, including basic services like health posts and water points. In many African countries the health system is falling short. In the first place States do not allocate sufficient funds to the health sector. Secondly, funds do not always reach the lower administrative levels in the rural and more remote areas. But also in the big cities of African countries, particularly in slums, health services are inadequate. Supplies may also be diverted at lower levels. Skilled personnel are in short supply, especially in remote areas. Sometimes local traditions and cultures contribute to health problems. Examples are early marriage (this increases the risk of complications during pregnancy and birth enormously); promiscuity (which increases the risk of spreading > sexually transmitted infections (STIs) and HIV/AIDS). Sometimes there are > taboos that bar discussion of certain topics and therefore stop sufferers from seeking medical help.

Some African countries have taken steps to improve people's health, for example child deaths from malaria have been reduced significantly in Kenya, Rwanda and Ethiopia.<sup>2</sup> However, many countries have failed to develop effective health plans and to provide sufficient resources to support health services.

Non-Governmental Organisations (NGOs) and Civil Society Organisations (CSOs) can make a significant difference by promoting the right to the highest attainable standard of health. NGOs and CSOs have encouraged governments to realise the right to health. They have done so by monitoring government policies, calling attention to violations of the right to health and empowering communities to participate in realising their right to health. In conjunction with the Main Book, this booklet explains how this can be done.

This booklet is divided into three sections and five appendices:

- Section 1 gives a brief introduction to the right to health and the main issues facing CSOs working on the right to health. Information is presented in two ways:
  - Basic info provides the reader with general information on an element of the right to health. It is indicated by a Basic info icon in the margin.
  - In-depth info provides the reader with additional information on the right to health. It is indicated by an In-depth info icon in the margin.

basic info 

in-depth info 

A reader wishing to understand the basic elements of the right to adequate health can read only the Basic info parts and proceed to Section 2.

- Section 2 gives advice on preparing to work on the right to health:
  - How to identify the State's obligations regarding the right to health;
  - What the role of non-State actors is concerning the right to health;
  - How to identify violations of the right to health;
  - Where to find the right to health in national laws and policies; and
  - Working with the community to develop and carry out a strategy.

- Section 3 is about realising rights in practice. It describes several activities to monitor and exercise rights associated with the main issues outlined in Section 1.
- There is a glossary, a list of acronyms and endnotes at the end of the book.
- There are five appendices:
  - Relevant extracts from international and African standards on the right to health;
  - A list of sources and resources on the right to health;
  - A list of organisations working on the right to health;
  - The Millennium Development Goals and their progress in Africa; and
  - A template for making your own checklist.

Users of this handbook are strongly advised to build links with health professionals and work with them.

The booklet may also be useful for health practitioners who wish to know about the human rights-based approach to health.

# 1 Understanding the right to health

This section briefly introduces the reader to the current situation of the right to health in Africa, what the right to health means, and some of the challenges that face CSOs working on the right to health.

## 1.1 The current situation of the right to health in Africa

---

According to the World Health Organisation (WHO), Africa carries 25% of the global health burden, but only has 1.3% of the global health workforce. Most countries on the continent will have to increase their capacity by at least 140% to cope with their growing health needs.<sup>3</sup>

Millions of mothers, newborn babies and children die every year from preventable and treatable diseases. “Every year 4.4 million children - including 1.2 million newborns - and 265,000 mothers die in sub-Saharan Africa. This amounts to 13,000 deaths per day or almost nine deaths every minute. Sub-Saharan Africa has the highest maternal mortality rate in the world. It also has half of the world’s maternal, newborn, and child deaths.”<sup>4</sup> About 60% of deaths of children under five years of age in some parts of Africa are related to malnutrition.<sup>5</sup>

Since the early 1990s, little progress has been made in maternal, newborn and child health in many parts of Africa and in some countries there has been a reverse. This is largely due to the HIV/AIDS > epidemic and armed conflicts. The HIV/AIDS epidemic causes health problems for mothers and newborns and in general puts a heavy burden on the health system. In areas of conflict, the health care system is heavily affected, while the need for health care increases.

> Infectious diseases (also called communicable diseases), many of which are preventable or treatable, are a major obstacle to human development in Africa. In fact, the main causes of death of children under five years of age are preventable and treatable diseases like pneumonia, diarrhoea and malaria. Under-nutrition increases the risk of dying from infections. According to the WHO, three diseases – HIV/AIDS, > tuberculosis and malaria – kill more than three million people in Africa every year. The number of cases of HIV/AIDS is particularly high in southern African countries. HIV/AIDS increases the occurrence of other infectious diseases, particularly tuberculosis. However, there has been some progress. According to the United Nations (UN)’s 2010 UNAIDS report, the rate of new HIV infections in sub-Saharan Africa decreased in 22 countries.<sup>6</sup>

> Non-communicable diseases – those that cannot be “caught” from another person, generally influenced by a more “urbanised” or luxury lifestyle. Such diseases, for example > diabetes and heart diseases, are a growing health problem in Africa. Although non-communicable diseases and injuries represent 27% of the region’s total disease burden, African governments do not, or cannot devote adequate resources to address the problem.

People living in Africa also face a number of environmental health risks. Unsafe water supplies, inadequate sanitation and unhygienic food preparation account for a high incidence of diarrhoea and infectious diseases. Many people also face unsafe working conditions through contact with chemicals, and sometimes high levels of air pollution. Climate change increases the risks of floods and droughts, both causing risks of diseases and disruptions of basic services.

Africa’s burden of death (mortality) and disease (> morbidity) is the result of various factors:

- Poverty and the poverty trap (see Figure 1);
- Lack of sustainable development and basic services;
- Environmental factors causing pollution; and
- Weak and poorly resourced health systems.

Figure 1: The poverty trap



**Box 1: Resources allocated by African governments to health care**

African countries allocate between 2 and 17 % of their government budget to health care; an average of around 10%. This is much less than necessary for maintaining a good standard of health for their growing populations. On average, the percentages spent on health have hardly increased since 1995, with the exception of Botswana, Burkina Faso, Liberia, Rwanda, and Tanzania which did increase their spending. Other countries including the Democratic Republic of Congo, Guinea-Bissau, Mali, Mauritania, Sierra Leone and even Kenya, have actually decreased their relative spending.

Source: WHO website, Data and statistics: [www.who.int/gho/health\\_financing/en/index.html](http://www.who.int/gho/health_financing/en/index.html) and [gamapserver.who.int/gho/interactive\\_charts/health\\_financing/atlas.html?indicator=i1&date=2009](http://gamapserver.who.int/gho/interactive_charts/health_financing/atlas.html?indicator=i1&date=2009)

**1.2 What is the “right to health”?**

**1.2.1 The right to health: what it is and what it is not**

The Constitution of the WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or > infirmity”. People who are weak through lack of food, violence, or living in unhealthy conditions are not in a state of “mental and social well-being”.

The terms “the right to the highest attainable standard of health” and “the right to health” are often used as a short version of: “*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*” – Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

The right to health is not the right to be healthy! States cannot be held responsible for everybody’s personal health, as this is dependent on individual factors and lifestyles as well. Each person faces periods of illness or lesser health. The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health. States parties to the ICESCR do have the responsibility to respect, protect, and take steps towards realising the right. Their governments are required to put in place action plans and policies which will lead to better health care for all in the shortest possible time.

CESCR is the body that oversees implementation of the ICESCR. It produces General Comments on aspects of the right to health. See the Main Book, Part I, Section 3.5.

The right to the highest attainable standard of health is not only about timely and appropriate medical care. It also refers to the underlying determinants of health. These

include health care, access to safe water and adequate sanitation, an adequate supply of safe food, adequate housing, and freedom from discrimination.

The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment No. 14 on the right to health, also lists some social factors essential to good health (the “social determinants of the right to health” including environmental safety, education, economic development and gender > equity). See also Section 1.2.2 below and Figure 2.

The Haki Zetu series contains separate handbooks on underlying determinants: The Right to Water and Sanitation, The Right to Food, and The Right to Adequate Housing.

### **1.2.2 Linking the right to health to other rights**

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For CSOs working on the right to health it is important to understand not only what the right to health means but also how it relates to other human rights.

The right to health includes the right to control one’s own health and body, including choices related to sexual and > reproductive health, and the right to be free from interference, such as torture, forced sex and being forced to undergo medical treatment.

The right to health also gives “entitlements” (things which we have a right to claim). These include the right of everyone to have access to health care.

To a large degree, good health depends on the underlying determinants of health including the social determinants. This shows that the right to health depends on, and contributes to, the realisation of many other human rights. These links are explained in Figure 2.

Other important rights that support the right to health are:

- The rights to equality and non-discrimination;
- The right to participate in all health-related decision-making at the community, national and international levels; and
- The right to receive and provide information (on matters related to health), in order to participate fully in decision making.

### **1.2.3 The main right to health violations**

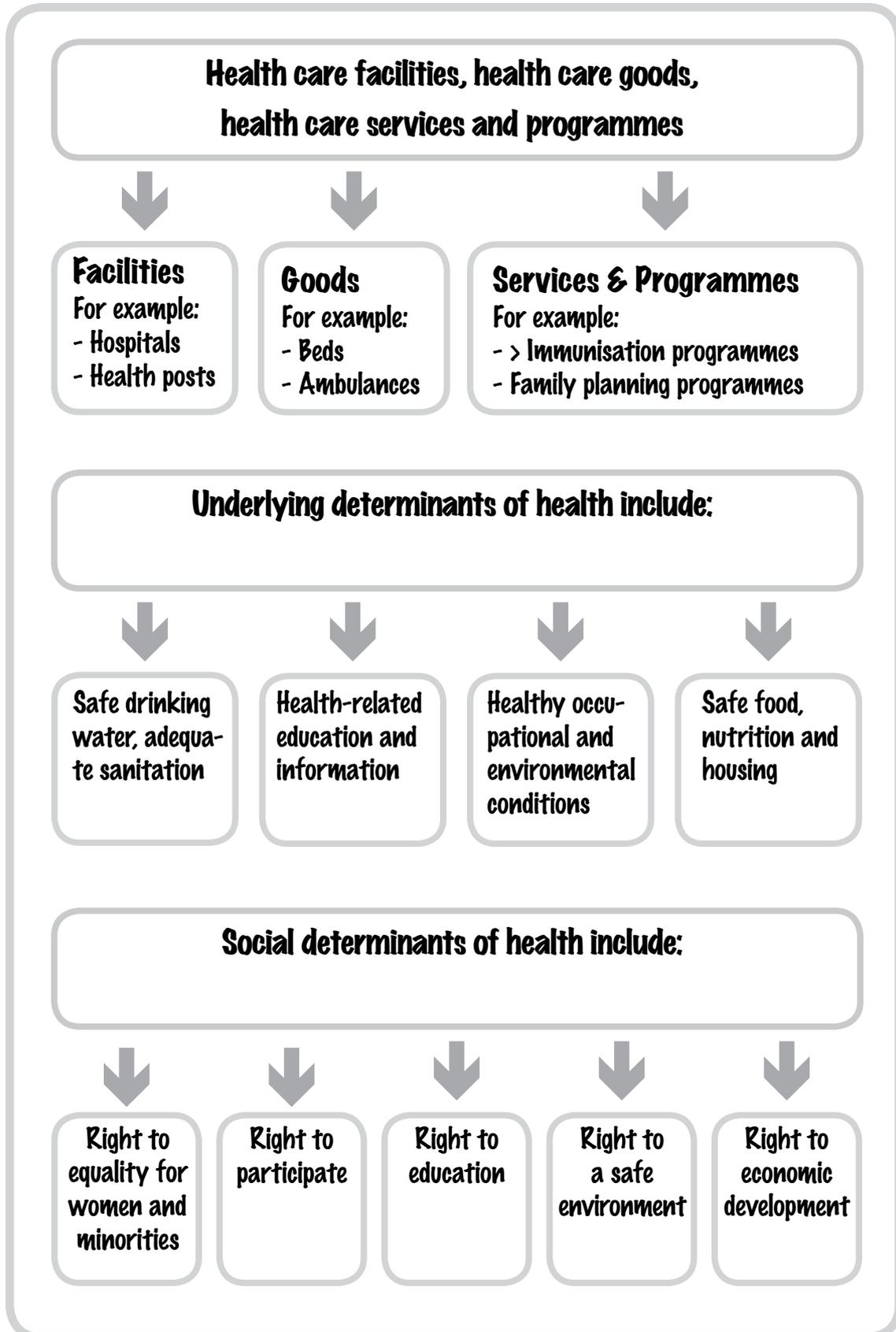
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Violations of the right to health can occur if governments do not respect, protect and fulfil the right to the highest attainable standard of health.

Violations occur when governments:

- Deny access to health facilities, goods and services to particular individuals or groups as a result of discrimination;

Figure 2: Determinants of the right to health



- Deliberately refuse to give information, or give misleading information that may be vital to health protection or treatment;
- Fail to take steps to improve the underlying determinants of health;
- Do little or nothing to reduce infant and maternal mortality rates;
- Fail to ensure healthy natural and workplace environments; and
- Neglect to set up systems to prevent, treat and control disease.

Non-State actors can commit similar actions, but these are commonly called “abuses”. Violations are discussed in more depth in Section 2.

## 1.3 Health systems and the right to health

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### 1.3.1 The basics about health systems and the right to health

basic info 

In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system. Yet according to the WHO, health systems in many countries are failing and collapsing.<sup>7</sup>

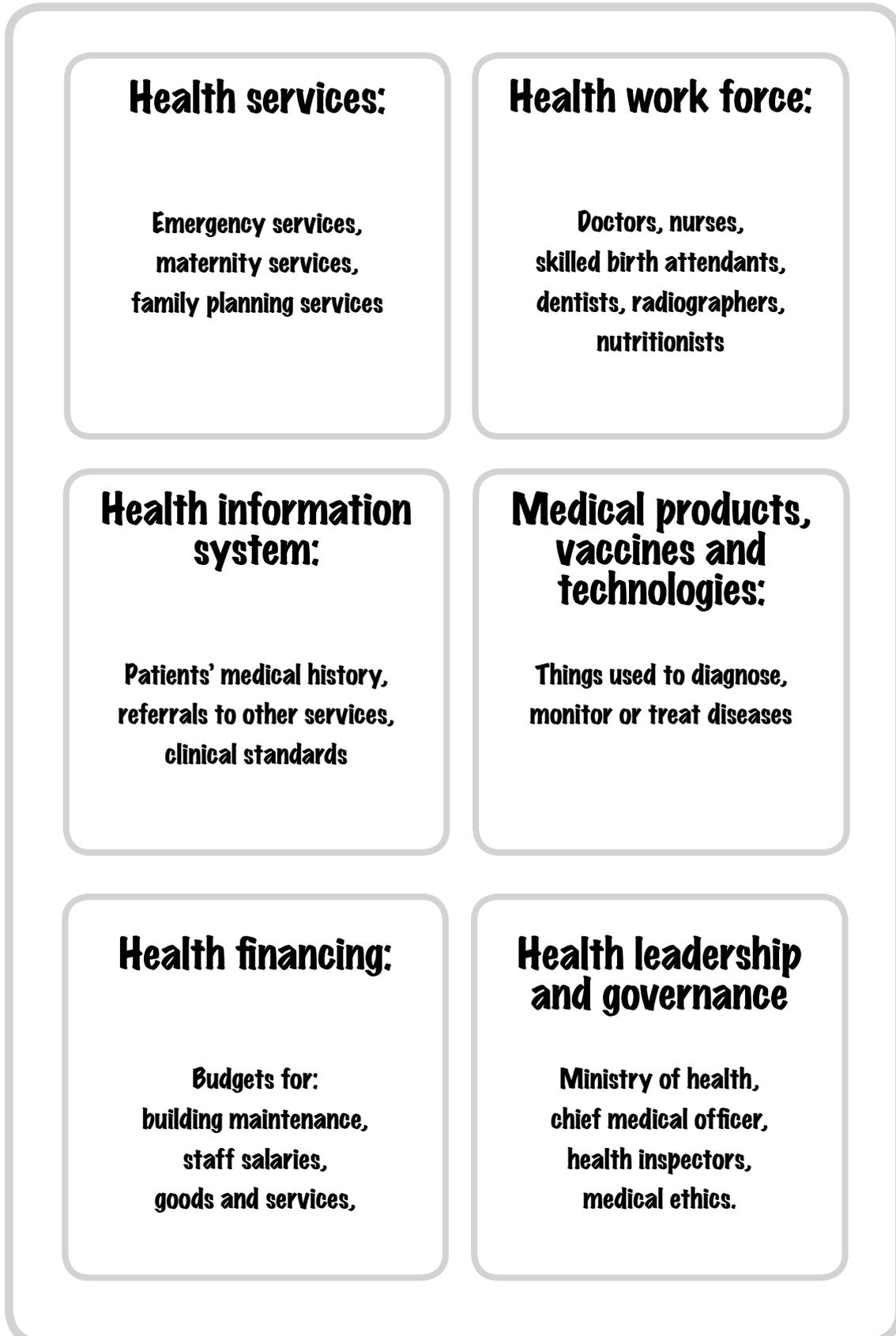
An effective and integrated health system is one that covers both health care and the underlying determinants of health. The system must be responsive to the national and local situations (population characteristics and trends, geographical factors, governance system, etc.), and it must be accessible to all.

The WHO identifies “six essential building blocks” which make up a health system that can deliver the highest attainable standard of health. These are: health services; health workforce; health information system; medical products, > vaccines and technologies; health financing; and leadership and governance.<sup>8</sup>

The building blocks can be undermined by lack of progress in improving underlying determinants: for example by failing to improve access to adequate housing, nutritious food and clean water and sanitation.

Government policies on health, housing and the environment should therefore be coordinated. Government ministries responsible for agriculture, water and sanitation, education, information and social services should all be involved. This is called a “multi-sectoral approach” to health problems.

Figure 3: The WHO's 'six essential building blocks' of a health system



### 1.3.2 More in-depth about health systems

Health systems are set up by States but they often involve contributions from non-State actors including private companies, international donors, international agencies and NGOs. For more information see Section 2.1.3.

There are three levels of health care: primary, secondary and tertiary.

Modern health systems have been influenced by the Declaration of Alma-Ata which was adopted at the International Conference on Primary Health Care in Almaty (formerly Alma-Ata) in Kazakhstan in 1978. The Declaration sets out primary health care principles and some essential health interventions (actions taken to prevent, improve or stabilise a health condition). The Alma-Ata principles of primary health care are given in Appendix 1, Table 5.

- **Primary health care** is about the prevention of illness or disability, for example programmes to immunise children, > family planning programmes, and malaria prevention. 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. Usually, this is provided through:



- Health posts or health stations, in which community health workers (see page 23) can provide basic medicines for common minor illnesses; and
- Health centres that can be found in towns or subdistricts and provide outpatient services including maternity services, through semi-skilled and professional medical staff.

The African Union (AU) Africa Health Strategy 2007-2015 advises States to strengthen and revitalise a primary health care approach. The AU developed this strategy to harmonise the existing health strategies in Africa.

- **Secondary health care** is for treating illnesses, such as bronchitis or tuberculosis and dealing with injuries such as a broken arm. Alternatively, it is all health care provided by medical specialists, in hospitals or special clinics (however, hospitals often also provide primary health care).



- **Tertiary (third level) health care** is for more difficult cases such as complicated surgical operations, for cancer management, heart surgery, etc., which is provided by highly trained specialists using often advanced technology in tertiary referral hospitals (often university hospitals).



### **Equality and non-discrimination**

A State has a legal obligation to ensure that health care and the underlying determinants of health are accessible to all without discrimination. This means that information and appropriate programmes must be in place to ensure that disadvantaged individuals and communities enjoy, in practice, the same access as those who are more advantaged.

Ensuring non-discrimination means that equal cases should be treated equally unless there are objective and reasonable grounds for providing different treatment. It does not mean that everyone should receive the same care. For example, it may be reasonable for children with poor eyesight to receive free spectacles, while adults in paid employment are expected to pay for theirs.

Discrimination in health care is often related to generational prejudices (for example, against youth), sexual orientation, and/or gender relations.

Many people face discrimination, disrespectful treatment, or lack of treatment, because of sexual taboos and social boundaries, for example:

- Women: who are not allowed to travel long distances alone to obtain medical care, or whose ailments are not given serious attention;
- Youth: who are denied the necessary information on sexuality and their rights, and/or who are not treated respectfully or are denied access to contraceptives or treatment for sexually transmitted infections (STIs);
- HIV-positive people who are denied treatment;
- Homosexuals, lesbians, > transgenders, men having sex with men, commercial sex workers who have no access to information and treatment; and
- Handicapped people, for example those living with albinism (see more in Box 7).

The obligation to end discrimination means that the State must keep up-to-date statistics to show which groups are suffering inequality and discrimination. To do this, governments must

collect > disaggregated information based on the prohibited grounds of discrimination (see the Main Book, Part I, Section 4.3 Box 10). However, many States do not make it a priority to gather data and publish it. One reason may be that they fear that the statistics would show their failings.

Gender inequality undermines women's health and access to health care, as the following facts show:

- Over half of those living in poverty are women;
- Every day, an average of 570 women in Sub-Saharan Africa die from complications in pregnancy or childbirth;<sup>9</sup>
- Women, much more than men, suffer domestic violence, forced sex and sexual assault. Often, their first sexual contact is forced; and
- Young women (15-24 years) are 2.5 to 4 times more likely to be HIV-infected than young men in Sub-Saharan Africa.

Further information on gender inequality may be found in Section 1.9.1.

For more on power relations between men and women, see the Main Book, Part I, Section 4.4.2

Women and girls have less access to education which is essential for making informed decisions about their own and their children's health care.

Although women are more affected, norms about manhood and rigid gender roles can also lead to discrimination against men.

### **The right to health information and the right to privacy**

The right to health requires the freedom to seek, receive and pass on information and ideas of all kinds. This includes health-related information and health education.

However, information about people's health status can be misused. "Health status" is information about what health conditions people have, for example HIV infection, cancer or > genetic disorders; or other factors such as their > sexual orientation, or their habits, for example if they smoke. Governments must therefore develop systems to ensure that the data are treated with care and confidentiality. People have a right to see their own health records.

### **The rights and duties of health professionals and health workers**

According to the Africa Health Strategy, the morale of health workers is generally low and patients complain of their negative attitude. For instance, health providers may be rude or deny people adequate care. They may be disrespectful towards young people or persons living with HIV/AIDS – especially regarding sexual and reproductive services – and also towards migrants.<sup>10</sup>

Health professionals are people with appropriate qualifications who are accountable to an independent > licensing body and to its standards and ethical principles.

Ethical principles for health professionals include upholding the right of patients:

- To be treated with respect (this also applies to members of their families and communities);
- To be given information about their treatment;
- To give or refuse consent to medical interventions (consent should be full, free and informed – this principle is described in the Main Book, Part II, Section 6.6 with regard to consent to be interviewed); and
- To confidentiality and privacy. Health professionals may not give information about a patient to anyone else without the patient’s consent.

### **Community health workers**

Community health workers are community members who are appointed by the community and who receive training and support from the health system. Their tasks may include health education, > environmental hygiene, first aid and treatment of simple and common ailments. Health professionals and other health workers also have the right “to work under equitable and satisfactory conditions, and shall receive equal pay for equal work” (African Charter, Article 15).

#### **Box 2: Using technology to improve health care delivery**

Health workers and telecom operators met in Accra, Ghana, in December 2010 to explore ways of using mobile phones to improve health care delivery for remote communities. There already exist many ways in which mobile phones can be used to improve health. For example, some health workers send text messages to remind patients to take their medicine. Text messages can also be used to test (and improve) people’s knowledge about avoiding diseases such as HIV and tuberculosis. They could also allow health workers in the field to receive information or advice from other health professionals.

Source: PlusNews. *Africa: Mobile phones for health*. December 2010. Available online: [www.plusnews.org/Report.aspx?ReportID=91287](http://www.plusnews.org/Report.aspx?ReportID=91287).

## 1.4 The right to health facilities, goods and services

### 1.4.1 The basics about health facilities, goods and services

basic info

Health facilities – hospitals, clinics and health posts – should be within easy reach. They should provide a range of essential health services for the > diagnosis (identification) and treatment of diseases.

Governments should work progressively to ensure that health facilities are distributed around the country according to need. The facilities should have the necessary staff, medical supplies and services to meet the needs of the population. This means using money wisely and targeting the most vulnerable.

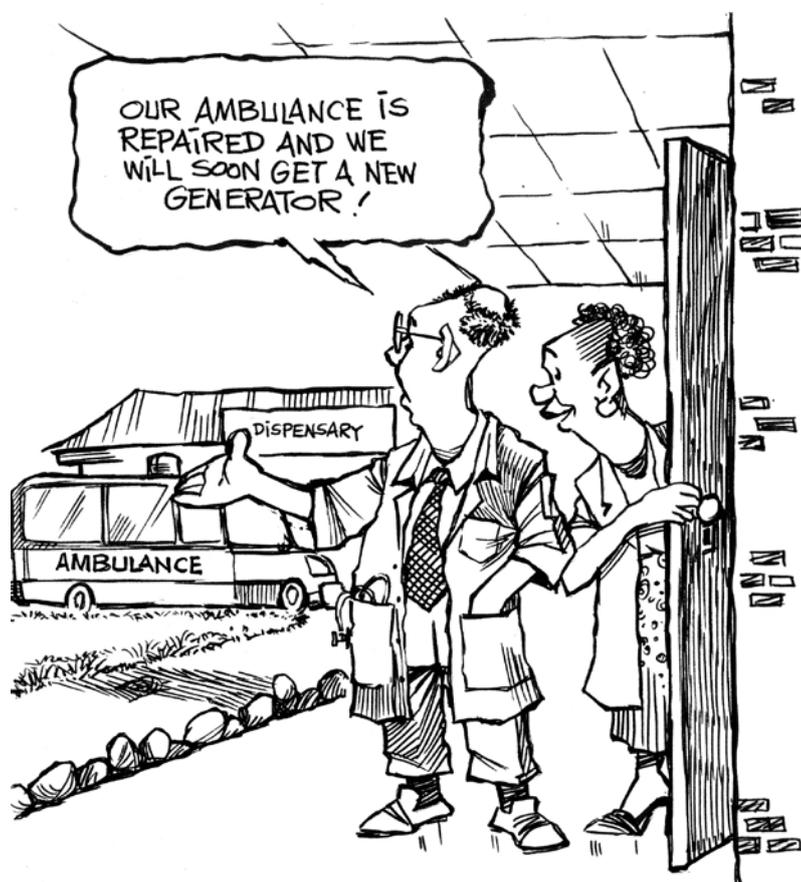
There are two main levels of facilities and services:

- Community level facilities and services; and
- District or provincial level facilities and services.

**Health facilities** include hospitals, clinics and health posts.

**Health goods** include medical equipment and drugs.

**Health services** are all the services needed to improve people's health, such as blood testing and health education programmes.



### **At the community level**

A community health facility (often called a “health post” or “health station”) should have:

- Enough trained personnel;
- Enough essential > drugs and other supplies;
- Health education material;
- Preventive services (such as screening to detect and prevent tuberculosis);
- Appropriate medical equipment;
- Other equipment, such as reliable telephones;
- An efficient record-keeping system;
- An efficient referral system to keep a record of patients’ treatment as they move through the health system (see below);
- Uninterrupted supplies of electricity and clean water; and
- Good management systems, including supply management (keeping track of supplies of equipment and drugs).

### **At the district or provincial level**

A fully-equipped health facility (clinic or hospital) would have:

- All of the above; and
- More advanced services, such as laboratories, blood banks, operation theatres > anaesthetists and X-ray equipment.

A third level facility is one with specialised staff and equipment for dealing with a specific type of problem, such as infectious diseases.

An adequate health system depends on good record keeping. This avoids mistakes such as giving the wrong medicine. Records also show patients’ medical history, their illnesses and the treatments they have received. Health systems should be well coordinated so that patients can be referred from one facility to another. An efficient referral system keeps records of patients’ treatment as they move through the health system, for example if they are sent to a specialist doctor or to a fully-equipped facility if necessary. Records should keep track of these referrals. Patients have the right to see their records and point out any mistakes.

Health facilities should not be overburdened with diseases that are preventable. An integrated health system will have:

- Programmes to improve the underlying determinants of health, particularly adequate housing, nutritious food and safe water and sanitation; and
- Public education programmes on health issues.

Unfortunately, many health facilities do not yet fit this description and cannot provide basic health care.

### 1.4.2 More in-depth about health facilities, goods and services and the underlying determinants of health

in-depth info

The CESCR's General Comment No. 14 on the right to health says that the right to health contains the following elements:

- Availability: health facilities, goods and services, as well as underlying determinants, have to be available in sufficient quantity.
- Accessibility: health facilities, goods and services and the underlying determinants have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:
  - Non-discrimination (they should be accessible by everyone without discrimination of any kind);
  - Physical accessibility (health care should be accessible throughout the country);
  - Economic accessibility (health care should be affordable to all); and
  - Information accessibility (information regarding health care and the underlying determinants should be freely accessible).
- Acceptability: health facilities, goods and services and underlying determinants must be:
  - Respectful of medical ethics;
  - Culturally appropriate;
  - Sensitive to gender and life-cycle (age) requirements; and
  - Designed to respect confidentiality and improve the health status of those concerned.
- Quality:
  - Health facilities, goods and services must be scientifically and medically appropriate and of good quality. Underlying determinants must also be of good quality.

Note: "Good quality" means that they must serve the purpose of providing good health care or promoting good health.

## 1.5 The right to sexual and reproductive health

Sexual and > reproductive health is a vital part of the right to the highest attainable standard of health. Sexual and reproductive health deals with all health matters related to sexuality, pregnancy and childbirth. The UN uses the terminology "maternal, child and reproductive health" to encompass these aspects.

Many elements of sexuality are non-reproductive. People engage in sexual intercourse not only to get children, but also as an expression of love and pleasure. Therefore, while sexual and reproductive health are closely linked, they are also distinct.

### 1.5.1 The basics about sexual and reproductive health and rights

basic info

Sexual and reproductive rights are central to the realisation of every individual's human rights. Respect for these rights is essential to human dignity and to the enjoyment of physical,

emotional, mental and social well-being. Various international instruments have recognised sexual and reproductive rights (see Appendix 1). States parties to the ICESCR are obliged to include these rights in their national laws.

According to the WHO, sexual health requires a positive and respectful approach to sexuality and sexual relationships, including the possibility of having pleasurable and safe sexual experiences.

Sexual rights include the rights of both women and men (including adolescents) to:

- Decide if, and when, to be sexually active or not;
- Not to be touched with sexual intentions, or have sexual relations, without mutual consent;
- Choose their partner;
- Marry with the partner of their own choice;
- Decide whether or not, and when, to have children;
- Pursue a satisfying, safe and pleasurable sexual life;
- Receive information about sexual health, and sexuality education;
- Receive help and advice if they are victims of rape and sexual abuse; and
- Have access to sexual and reproductive health care services, including access to prevention and treatment of sexually transmitted diseases, such as HIV/AIDS.

Reproductive rights include the rights of both women and men (including adolescents) to:

- Decide freely the number, spacing and timing of their children;
- Have access to information and education about sexuality and reproductive health;
- Be informed of and have access to safe, effective, affordable and acceptable methods of > family planning (including > contraception);
- Have access to goods and services to prevent avoidable maternal mortality (death) and morbidity (disease);
- Have access to goods and services to take care of their children (safe motherhood);
- Be free from forced > sterilisation, forced abortion, and forced pregnancy; and
- Be free from forced marriage (including for children) and harmful traditional practices endangering sexual and reproductive health, such as female genital mutilation (FGM).

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol or Maputo Protocol), in Article 14, adds that the right to reproductive health includes women's rights to be informed of their health status and of their partner's health status, particularly if affected with STIs including HIV/AIDS, in accordance with internationally recognised standards and best practice.

The above sexual and reproductive rights are also applicable to adolescents and youth as articulated by a series of international conferences (Cairo Conference on Population and Development, Beijing on Women), charters (African Youth Charter) and principles (for example of the IPPF).

While sexual and reproductive rights need to take into consideration existing cultural and social contexts, socio-cultural arguments should not be used to deny these rights.

### **Sexual identity**

Everyone has a > sexual identity (heterosexual, homosexual, transgender and the like) and rights that protect this identity. These include the rights to:

- Non-discrimination and equality before the law;
- Privacy and family life;
- Freedom from physical ill-treatment;
- Freedom of expression and association;
- The highest attainable standard of physical and mental health; and
- Freedom to decide on matters related to their sexuality, sexual and reproductive health, and freedom from coercion (force) of any kind.

### **1.5.2 More in-depth about sexual and reproductive health including family planning**

in-depth info 

Reproductive health is a lifetime concern for both women and men, from infancy to old age. During the reproductive years, information about sexual and reproductive health is essential, particularly for teenagers and young adults. Health care during this period includes family planning, care in pregnancy and childbirth, and dealing with STIs and reproductive tract infections. Health problems at more advanced ages include chronic infection and the possibility of cervical and breast cancer in women and prostate cancer in men.

For many years women have been both the principle targets and beneficiaries of family planning and reproductive health programmes. Policy makers, health planners and service providers are now paying more attention to the influential role that men play in the sexual and reproductive health of their families and sexual partners. This is crucial for their own sake as well as for the well being of their partners and families. Male attitudes towards gender and sexual relations arise in boyhood, when they are often set for life. Men and boys need to learn about sexual responsibility and equality in intimate relationships. This can only be achieved through ongoing awareness raising about healthy sexual and reproductive behaviour. Both sexes need reproductive and sexual health care appropriate to their age.

### **Sexually transmitted infections (STIs) including HIV/AIDS**

Sexual health can be undermined by infections and diseases, such as > chlamydia and > gonorrhoea, which are caused by > bacteria passed between sexual partners when they have unsafe (unprotected) sex. Using a > condom usually prevents sexually transmitted infections (STIs). Having different sex partners increases the risk of STIs. Almost all STIs can be cured if they are detected at an early stage.

The Human Immunodeficiency > Virus (HIV) is also transmitted through unprotected sex. It leads to Acquired Immune Deficiency Syndrome (AIDS) and cannot be treated. Having the right medicines can help sufferers to live longer. HIV is best prevented by avoiding multiple sex partners and using condoms.

For more information on HIV/AIDS, see Section 1.8.6



**Family planning and abortion**

Family planning is sometimes known as “child spacing”. Having several babies within a short time is dangerous both for the mother and her babies. Large families can also lead to family poverty.

Family planning services should offer appropriate information and advice and provide a range of contraceptive choices, such as (male and female) condoms, contraceptive pills and Intra-Uterine Devices (IUDs), inserted into the uterus or womb. In Sub-Saharan Africa only 17% of married women use reliable contraceptives, although the demand is much higher.<sup>11</sup> This is called the “unmet need”. Access can be a problem due to lack of information, lack of availability or because of costs involved.

Many girls and women have unwanted pregnancies (39% of pregnancies in Africa are unwanted/unplanned).<sup>12</sup> One reason is the lack of contraceptives. Others include rape, incest, being young, not ready for motherhood, or already having many children (hard to feed). A major underlying cause is the fact that women and girls are often unable to decide for themselves whether and how to have sex due to religious, cultural and traditional beliefs. Faced with unwanted pregnancy, they, not their partners, often bear the consequences. This leads to social > stigma and school drop out. It can even drive women into commercial sex work to feed the child.

### Abortion<sup>13</sup>

In many countries > abortion is a criminal offence (although the law may make an exception may be when abortion is necessary to save a woman's life). Even where abortion is legal it may be unaffordable. In this case only those who can afford good (private) health services have access to safe abortions by trained medical personnel, using the right instruments and/or medicines. The majority of girls and women have to rely on unsafe abortions, done by unskilled persons, using domestic, unsterile (infected) tools and/or herbs. These can seriously damage the womb, lead to bleeding and even death. Some women and girls try to abort the > foetus using broken bottles and high doses of medicines. In Africa, 97% of abortions are unsafe, and the number of unsafe abortions is increasing. Sixty percent of women under 24 years of age have unsafe abortions. Unsafe abortions cause one in every seven or eight maternal deaths. Where abortions are legal – such as in Ethiopia and South Africa – and accompanied by proper procedures, unsafe abortions and the number of deaths are going down. In South Africa, where abortion was legalised in 1996, the death rate due to abortion decreased by 91%.

Access to safe abortion is an essential element of the rights to the highest attainable standard of health, to privacy, to be free from cruel, inhuman or degrading treatment, and to make decisions about one's reproductive health and life.

The Africa Health Strategy<sup>14</sup> calls for family planning to be part of a wider sexual health programme that also provides:

- Screening and treatment for STIs;
- Safe abortion services;
- Advice on > infertility and > menopause;
- Gender and sexuality education programmes;
- Youth and women-friendly services, with a specific focus on reducing teenage pregnancies and sexually transmitted diseases; and
- Access to > post-exposure contraception for victims of rape.

### 1.5.3 The basics about maternal and child health



As noted in Section 1.1, Africa has the highest maternal mortality rate in the world. It also has a high rate of infant mortality. This is when babies die before, during or after birth. In most cases the deaths could have been prevented. Women and girls die because they do not have easy access to medical care, especially obstetric care (see below). > Pre-natal examinations often reveal problems which, if they are recognised at an early stage, can easily be resolved. There is a serious lack of skilled > midwives in many countries. Medical facilities may lack the necessary equipment to deal with emergencies.

States are obliged, under Article 12 of the ICESCR and Article 14 of the African Women's Protocol, to take steps to reduce maternal and child mortality. This requires measures to:

- Improve maternal and child health;
- Provide sexual and reproductive health services, including access to family planning;

- Provide pre- and post-natal care, including emergency > obstetric (childbirth) services (sometimes referred to by the acronym EmOC); and
- Ensure access to information.

In 2000, world leaders agreed to formulate eight Millenium Development Goals (MDGs; see Appendix 4). While health is prominent in all goals, Goal 4 deals specifically with maternal health. In 2005 it was reformulated as "achieving universal access to reproductive and sexual health services." For more information on the MDGs and their impact on the right to health, see Appendix 4.

#### 1.5.4 More in-depth about maternal mortality

in-depth info

As noted in Section 1.3.2, around 570 women in Sub-Saharan Africa die from pregnancy- or childbirth-related complications every day. With this, Sub-Saharan Africa accounts for more than half of global maternal mortality.<sup>15</sup> The global rate of maternal mortality has dropped, but in Africa the numbers have remained high. Complications arising before, during and after childbirth cause 85% of all maternal deaths.

#### The main medical causes of maternal mortality<sup>16</sup>

The complications that account for most maternal deaths are:

- Severe bleeding (mostly bleeding after childbirth), called > haemorrhage;
- Infections (usually after childbirth), or > sepsis;
- High blood pressure during pregnancy and/or when a woman falls into a coma or has convulsions shortly before or after the birth (pre-eclampsia and > eclampsia);
- Obstructed labour; and
- Unsafe abortion.

The remainder are caused by diseases such as malaria, anaemia and HIV/AIDS during pregnancy.

#### Box 3: The three delays

Delayed treatment is a major reason why women die when they have complications during pregnancy and childbirth. There are three main types of delay and each one is closely related to the lack of one or more elements of the right to health:

**Delay** in seeking appropriate medical help for a childbirth emergency because of:

- Cost;
- Failing to recognise the urgent need for medical attention;
- Lack of information about the risk factors; or
- The mother's lack of authority within the family to make decisions;

> continued

**Delay** in reaching an appropriate facility because of:

- Distance, bad roads or lack of transport;

**Delay** in receiving adequate care after reaching a facility owing to:

- Staff shortages, lack of required skills, equipment or drugs; or
- Lack of electricity, water or basic supplies.

### **Indirect causes of maternal mortality**

There are a number of indirect causes of maternal mortality, including:

- Lack of information about the main causes and the risk factors;
- Weak health systems that cannot respond to emergencies;
- Discrimination against women and lack of women's empowerment;
- Cultural and social barriers including:
  - Early marriage and early pregnancy: young girls are physically not developed enough for child bearing and pregnancy might cause serious physical and mental problems;
  - Domestic violence and sexual assault or rape;
  - FGC/FGM, which increases the risk of childbirth complications and newborn deaths;<sup>17</sup>
  - Low status of women within the family; and
- When women have no knowledge of or access to family planning and contraception.

### **Risk factors**

There are also a number of risk factors to consider:

- Repeated pregnancies: the risk is repeated every time a woman becomes pregnant; the older she is, the greater the risk. Reducing the number of pregnancies would reduce maternal mortality; and
- Women who are > anaemic (do not have enough red blood cells).

Most of these deaths, whether from medical or social causes, are preventable.

Various health interventions are necessary for reducing maternal mortality. They include:

- Emergency obstetric care (EmOC);
- A skilled birth attendant;
- Education and information on sexual and reproductive health;
- Safe abortion services;
- Other sexual and reproductive health care services, such as family planning services; and
- Primary health care services.

### **Emergency obstetric care**

Such care is needed for women experiencing complications during childbirth. There are two kinds of emergency obstetric services – basic and comprehensive.

- Basic services include the provision of antibiotics and other medicines and procedures such as the manual removal of the > placenta (lining of the womb); and
- Comprehensive services include all the basic services and also facilities for operating (opening the womb to remove the baby or “caesarean section”) and blood transfusion.

### Skilled birth attendants

According to the WHO, a skilled birth attendant is a qualified health professional – such as a midwife, doctor or nurse – who has been properly trained in the skills needed to assist mothers in normal (uncomplicated) pregnancies, in the delivery of babies, and in the immediate period after the birth, known as the post-natal period. The attendant should also be able to identify complications in mothers and newborn babies and refer them to the appropriate specialists. Traditional birth attendants (TBAs), who are not formally trained, do not meet the definition of skilled birth attendants. Some women may prefer to deliver at home, with the help of a TBA, especially where hospitals are distant and staff not always respectful. More effort should be made to improve access to skilled birth attendants.

In addition to providing the goods and services necessary to prevent maternal mortality (as listed above), the State must address the right to the underlying determinants of health listed in Figure 2. The majority of these determinants have a direct influence on maternal health.

The State also has an obligation to increase awareness of the warning signs that indicate problems during pregnancy, childbirth, and post-childbirth (bleeding, pain, persistent fever, foul-smelling discharges, etc.).

## 1.6 The right to mental health

basic info

### 1.6.1 The basics about mental health

Mental health is influenced by social, cultural and medical factors. Infectious diseases such as malaria, > typhoid fever and epilepsy can affect the brain and thereby cause > psychosis. Psychoses are also caused by malnutrition or inadequate care at childbirth. > Post-traumatic stress disorders are prevalent. They are caused by conflicts and social problems. Finally, alcohol, tobacco and drug abuse are an increasing concern in Africa. Excessive consumption of home-brewed beer or locally distilled liquor affects the mental health of many.<sup>18</sup>

People with mental illness suffer discrimination and exclusion in many communities (and even neglect in their own families – women more than men) and States seldom provide sufficient resources for mental health (in Africa less than 1% of the health budget is spent on mental health).<sup>19</sup> A major problem is lack of awareness about mental health. Some people fear that the mentally ill may be violent. Some assume that the mentally ill are somehow responsible for their condition.

### 1.6.2 More in-depth about mental health

The rights of people with mental disabilities are protected by the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991).

In Africa, where governments are struggling to deal with infectious diseases and malnutrition, mental health is usually neglected. Yet, according to the World Psychiatric Association, mental disorders are a significant part of the burden of disease and mental health should be given adequate attention and resources.<sup>20</sup>

In 1988 member States in the African Region of the WHO agreed to develop mental health policies, programmes and action plans. However, few countries have done so. In many countries, mental health laws are out of date; there are very few psychiatrists (mental health doctors) and a lack of mental health facilities.<sup>21</sup> Furthermore, few countries collect data about mental health.



#### Box 4: Raising awareness about mental health

The South African Depression and Anxiety Group (SADAG) works to educate members of the public about mental wellness and to eradicate the > stigma that mentally ill people suffer. SADAG runs a telephone help line. “Many of our callers have no access to treatment, or psychiatric facilities in their area as many have been closed,” says SADAG’s Counselling Services Manager, Cassey Amoo. “We know how difficult it is for patients with psychiatric illnesses to get the appropriate help. We are trying to raise awareness in government that mental health should get more attention – and more money.”

Source: [www.sadag.co.za](http://www.sadag.co.za).

1.7

The right to healthy natural and workplace environments

1.7.1 The basics about healthy natural and workplace environments

basic info

Our environment influences our health in many ways. Exposure to air and water pollution, for instance, can undermine human health. Diarrhoeal disease, lower respiratory tract infections, unintentional injuries, and malaria are all related to environmental factors. As much as 24% of global disease, and even 33% in children under the age of 5, is caused by environmental exposures which can be avoided.<sup>22</sup>

The CESCR emphasises that a clean and healthy environment is a part of the right to health. It requires States to:

- Ensure that employers take steps to prevent work related accidents and diseases;
- Provide everyone with access to an adequate supply of safe drinking water and basic sanitation (see also the Haki Zetu booklet on the right to adequate water and sanitation);
- Prevent and reduce people’s exposure to harmful substances such as radiation and dangerous chemicals or other environmental conditions that directly or indirectly affect human health; and
- Adopt policies aimed at reducing and eliminating pollution of air, water and soil.

Box 5: Climate change and health

Our environment is increasingly affected by climate change. It is predicted that this will have both direct and indirect effects on health.

- The **direct** effects include ill health caused by exposure to:
  - Extremes of temperature, both hot and cold;
  - Extreme weather events, such as floods, cyclones, storms and droughts; and
  - Increased production of air > pollutants including heavy metals such as lead from gasoline (petrol).
- **Indirect** effects include:
  - The reduction of food productivity; and
  - The increased > transmission of many infectious diseases, particularly water and food borne diseases such as malaria and salmonella.

Refer to the Glossary in the Main Book for definition of climate change.

In Sub-Saharan Africa, which already accounts for around 90% of the world’s malarial deaths, malaria cases are projected to increase by an extra 400 million cases by 2080. Developing

> *continued*

country populations, particularly in small island States, and in densely populated coastal areas, are particularly vulnerable to climate change.

Source: *Warmer temperatures spreading malaria in Africa*, the Ecologist, 4th January, 2010, [www.theecologist.org/News/news\\_round\\_up/391702/warmer\\_temperatures\\_spreading\\_malaria\\_in\\_africa.html](http://www.theecologist.org/News/news_round_up/391702/warmer_temperatures_spreading_malaria_in_africa.html).

## 1.7.2 More in-depth about healthy natural and workplace environments

in-depth info

### Air pollution

Africa is behind the rest of the world in reducing lead in gasoline. Lead from vehicle emissions enters body tissues and makes people sick. It also reduces mental capacity, particularly in children. In adults, lead pollution affects the heart, the nervous system and the kidneys. Diesel fuel releases oxides which cause respiratory (breathing) diseases. Smoke pollution from wood fires in the home for cooking and heating, forest and bush fires and the burning of rubbish also cause respiratory diseases.

### Water and soil pollution

Water that is polluted by human > faeces causes infectious diseases including > cholera, typhoid, hepatitis and polio. The WHO estimates that about one and a half million children die annually from diarrhoeal diseases.<sup>23</sup>

Water and soil pollution from industrial or agricultural chemicals also cause disease and death. For example, plastic bags and electrical appliances contain chemicals that pollute soil and water. People working in waste collection and recycling, and workers in the mining sector run a great risk of contracting a disease. Pollution also destroys the ecosystem or natural environment. Ending pollution is costly, but governments have a duty to adopt and enforce regulations to control pollution. Increasingly, governments are held responsible for protecting people in other countries suffering from the pollution they cause.

### Box 6: Toxic waste dumping leads to serious health problems in Ivory Coast

People in Africa are often exposed to serious health risks due to inadequate (enforcement of) rules on waste dumping and treatment. In August 2006, toxic waste was brought to Abidjan, Ivory Coast, on board the ship Probo Koala, which had been chartered by the oil-trading company Trafigura. This waste was then dumped in various locations around the city, causing a human > *continued*

rights tragedy. More than 100,000 Ivorians sought medical attention for a range of health problems and there were 15 reported deaths.

Following legal actions in Europe, the company was fined and some victims received compensation (though there were several irregularities in this process).

Sources: Amnesty International press statements, [www.amnesty.nl/nieuwsportal/pers/trafigura-guilty-verdict-upheld-in-toxic-waste-dumping-case](http://www.amnesty.nl/nieuwsportal/pers/trafigura-guilty-verdict-upheld-in-toxic-waste-dumping-case) and [www.amnesty.nl/nieuwsportal/pers/cote-d-ivoire-missing-millions-must-reach-trafigura-toxic-waste-victims](http://www.amnesty.nl/nieuwsportal/pers/cote-d-ivoire-missing-millions-must-reach-trafigura-toxic-waste-victims).

## 1.8 The right to prevention, treatment and control of diseases

### 1.8.1 The basics about prevention, treatment and control of diseases

basic info

The right to health requires States to put in place programmes and services, including:

- **Prevention**
  - Making regulations to prevent the spread of diseases, for example to control the movement of cattle to prevent the spread of > sleeping sickness;
  - Health promotion programmes to give advice about health problems, particularly those caused by smoking, alcohol abuse, lack of exercise and unhealthy diets;
  - Education and information programmes about diseases such as HIV/AIDS, malaria and tuberculosis (TB);
  - Programmes to promote environmental health; and
  - Providing information about health risks and how to avoid them.
- **Treatment**
  - The provision of equal and timely access to health care services;
  - Regular screening programmes; and
  - Appropriate treatment of diseases, illnesses, injuries and disabilities, including at community level.
- **Control**

Enforcing regulations, for example, making sure that there are:

  - > Immunisation programmes to control infectious diseases; and
  - Programmes to eliminate the breeding places of insects that carry diseases, such as stagnant water where mosquitoes breed.

### 1.8.2 More in-depth about prevention, treatment and control of diseases

in-depth info

The right to health, as explained in the CESCR's General Comment No. 14, requires States to:

- Carry out immunisation programmes against the major infectious diseases (see Section 3.7);
- Provide appropriate training for doctors and other medical personnel;

- Build a sufficient number of hospitals, clinics and other health-related facilities, which should be distributed throughout the country in a fair way;
- Set up an appropriate health insurance which is affordable to all; and
- Promote health education, including through information campaigns, in particular with respect to HIV/AIDS (see Box 14), sexual and reproductive health, traditional practices, and domestic violence.

### 1.8.3 Neglected diseases and the right to health

Some diseases are more common among disadvantaged groups. They are known as “neglected diseases” or “poverty related diseases”. They include > river blindness, > trachoma (another type of blindness), > leprosy, sleeping sickness and tuberculosis. These diseases tend to share some common features:

- They typically affect women, children, ethnic minorities, displaced people, and those living in remote areas with restricted access to services;
- They can often be prevented through basic public health measures, such as access to education, clean water and sanitation and improved housing and nutrition (see other booklets in this series);
- Where treatment exists, people do not receive it early enough; and
- The development of drugs for tropical diseases and diseases linked to poverty, such as tuberculosis, has been neglected. Drug companies make more profit by producing drugs which can be more easily purchased by people with greater incomes.

#### Box 7: Stigma and discrimination

Some diseases or conditions are neglected because they give rise to fear, discrimination and stigma, either because people are disgusted by the condition or do not understand the cause. They are neglected also because of lack of investment and research by States into treatment for these diseases. Sometimes, people fear that it is the result of some sort of curse. Such conditions include leprosy, obstetric > fistula and > albinism.

##### **Obstetric fistula**

This occurs after a difficult birth causes a hole between the rectum and the vagina or the bladder and the vagina. It causes incontinence (the inability to control) of faeces or urine or both. Early marriage and FGC/FGM can also cause obstetric fistula.

##### **Albinism**

Persons with albinism have pale hair, eyes and skin. Their eyesight is poor and their skin is

*> continued*

sensitive to sunlight. The condition is caused by lack of the gene that produces melanin – the pigment that protects the skin from ultraviolet light from the sun. Persons with albinism are often avoided, stigmatised and discriminated against.

In Tanzania, 25 persons with albinism, including children, were murdered in 2008 and their body parts removed for ritual purposes due to a false belief that they possess magical powers. The authorities arrested 173 people in connection with the killings.

Source on fistula: [www.forwarduk.org.uk/key-issues/fistula](http://www.forwarduk.org.uk/key-issues/fistula).

Source on albinism: *Living in fear: Tanzania's albinos*, 21 July 2008. Available online: [news.bbc.co.uk/2/hi/africa/7518049.stm](http://news.bbc.co.uk/2/hi/africa/7518049.stm).

See also: M. Thuku (2011), *Myths, discrimination and the call for special rights for persons with albinism in Sub-Saharan Africa*. Available online: [www.amanikenya.com/wp-content/uploads/2011/04/Rights-for-People-with-Albinism-in-Africa.pdf](http://www.amanikenya.com/wp-content/uploads/2011/04/Rights-for-People-with-Albinism-in-Africa.pdf).

#### 1.8.4 Access to essential medicines (drugs)

The right to health includes the rights to prevention, treatment and control of diseases and access to essential medicines or drugs, medical products and medical technologies. Essential drugs are those “that satisfy the priority health care needs of the population”. Essential medicines must be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality and at a price the individual and the community can afford (WHO, 2000).

The African Commission Resolution on Access to Health and Needed Medicines in Africa (Resolution 141, 2008) states that “States parties to the African Charter have an obligation to provide where appropriate needed medicines, or facilitate access to them.”<sup>24</sup>

Medicines should be scientifically tested and approved and “unexpired”. Drugs can become useless or dangerous after a certain time, so an expiry date must be given on the package.

To comply with human rights principles, essential drugs must be accessible, available, appropriate and of assured (tested) quality.

Health facilities should have stocks of essential drugs as defined by the WHO Action Programme on Essential Drugs.<sup>25</sup>



#### Box 8: Harmful practices

States are obliged to take action to eliminate harmful traditional practices. Those that mainly affect women and girls include > female genital cutting (FGC), also known as female genital mutilation (FGM), early marriage, forced marriage, and nutritional taboos (beliefs that the consumption of particular, often nutritious animal meat or plants is harmful, especially to pregnant women, and the custom of giving better and more high-protein food to male children).

In some countries people are hunted down for the purpose of removing of human organs for sale as magic potions or for transplants. Vulnerable people, particularly women and children, have been attacked after being accused of witchcraft. Child trafficking and the worst forms of child labour, including forced prostitution and child soldiers, are also extremely harmful to health.

For more information, see *OHCHR Fact Sheet No.23, Harmful Traditional Practices Affecting the Health of Women and Children*, available online at [www.ohchr.org/Documents/Publications/FactSheet23en.pdf](http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf).

#### 1.8.5 International dimensions of health

Health is not just a national issue. Infectious diseases and events that undermine health, such as desertification or floods, often cross national borders. On the other hand, health-related developments in one country can benefit people in other countries.

All States have a responsibility to cooperate concerning health issues that cross borders. At a minimum, States must cooperate with their neighbours and “do no harm” to them, for example they must alert a neighbour to any potential hazard, such as a health epidemic near a border. States with sufficient resources have a responsibility to assist those with lower incomes (see the Main Book, Part I, Section 4.2, Table 5).

Cooperation on health issues in Africa include the 2008 Libreville Declaration on Health and Environment in Africa in which States have agreed to carry out a series of actions and to report on their achievements in 2012.<sup>26</sup>

### 1.8.6 HIV/AIDS and the right to health

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#### **What is HIV/AIDS?**

The Human Immunodeficiency Virus (HIV) damages the body’s immune system which protects the body against infection by bacteria, > viruses and other > parasites. When a person is HIV-positive, her/his body becomes increasingly vulnerable to infections and diseases, and over time an infected person will become ill more frequently and more severely. At that point, a person is said to have developed AIDS, the Acquired Immune Deficiency Syndrome.<sup>27</sup>

Having HIV, or “being HIV positive” is therefore not the same as having AIDS. Many HIV positive people live with the disease for years. There is no cure for the virus, but there are drugs that can slow it down; these drugs are known as anti-retroviral drugs (ARVs), with the treatment known as > antiretroviral > therapy (ART). Though these drugs are becoming increasingly available, less than 50% of HIV-positive people in Africa have access to ARVs<sup>28</sup> and consequently many still die due to AIDS.

In 2009, 33 million people worldwide, including 23 million (68%) in Africa, were infected by HIV.<sup>29</sup> HIV/AIDS hits women and girls disproportionately, as it is related to poverty, gender inequality, being able to decide about one’s sexuality and sexual and gender-based violence (SGBV). Also due to biological factors, women and girls catch the virus more easily: adolescent girls in Sub-Saharan Africa catch the virus eight times more than young males, and 71% of all 5-24 year-olds living with HIV are women.<sup>30</sup>

#### **How is it transmitted?**

HIV is passed from one person to another through the exchange of body fluids, by having sex, by > injecting with a needle that an infected person has used, by being born when the mother is infected, or by drinking the breast milk of an infected woman. Unprotected sex is the main cause of HIV infection and mother-to-child transmission is a second one.

#### **How can it be prevented?**

- By refraining from having many sexual partners;
- Using a condom;

- Avoiding injecting drugs, but if this is necessary, always use new and disposable needles and syringes;
- Ensuring that any blood or blood products used are tested for HIV, and
- Taking a test to find out your HIV status, then getting treated and adapting your behaviour to avoid spreading of the virus.

#### Box 9: Traditional medicines and HIV/AIDS

According to the WHO, up to 80% of people in some African countries use traditional medicine for primary health care.

The HIV/AIDS epidemic has focused attention on the use of traditional medicine. Traditional healers include “diviners” who use supernatural methods and “herbalists” who use plants. Some use both. The internet gives pages of recipes for traditional herbal remedies which are said to cure HIV/AIDS. None of these methods has been scientifically approved as a cure for HIV/AIDS. Those who seek traditional treatment delay reaching effective medical help.

Some traditional medicines may be effective in treating other conditions. WHO studies have found herbal medicines that could combat malaria. The Africa Health Strategy states that governments should integrate traditional medicines into national health systems and policies and that, in collaboration with traditional health practitioners and communities, the existing systems should be analysed and best practices should be strengthened. Integrating traditional medicine into the health system could include training healers to provide counselling and basic health care.

Sources: WHO Fact Sheet No. 134 (2008) on traditional medicine.

Available online: [www.who.int/mediacentre/factsheets/fs134/en/](http://www.who.int/mediacentre/factsheets/fs134/en/).

Marlise Richter, Discussion paper prepared for the Treatment Action Campaign and AIDS Law Project, 27 November 2003.

Dr. Steve Novella. *WHO partners with traditional healers*. Available online: [www.sciencebasedmedicine.org/?p=6698b](http://www.sciencebasedmedicine.org/?p=6698b).

#### What problems do people living with HIV/AIDS face?

Many people living with HIV/AIDS do not know their status (ranging from about 30% in Kenya to close to 70% in the Congo).<sup>31</sup> When their status becomes known, they usually face stigma, prejudice, discrimination, loss of contact with their families, loss of employment and property, and even life threatening exposure to violence. This is a major obstacle against getting tested and receiving advice.

Prejudices and myths are very strong. People with HIV/AIDS are exposed to:

- Ignorance and myths: for example, belief in the myth that the disease can be passed on

by shaking hands or sitting next to a person living with HIV/AIDS;

- Prejudice and stigma: people associate HIV/AIDS with what they regard as negative behaviour such as homosexuality, sexual promiscuity (many partners), prostitution and drug use;
- Criticism on moral or religious grounds: people with HIV/AIDS are assumed to be morally weak; and
- Myths, for example the belief that having sex with a virgin prevents HIV/AIDS; in fact this exposes girls to rape and infection.

Women and girls may face stronger stigmatisation, as they are often assumed to be promiscuous (having multiple sexual partners).

People with HIV/AIDS and their families face threats and hardships:

- Being excluded by their communities, thrown out of jobs or homes;
- Family members give up jobs or schooling to take care of relatives with HIV/AIDS so family incomes drop; and
- Being denied adequate access to information necessary to make informed decisions and to receive care and treatment.

Some States have passed laws to restrict the movement of people with infectious diseases such as HIV/AIDS on grounds such as national security. Restrictions are only justified if they are carried out in accordance with the law and in the interest of legitimate aims. Some laws provide prison sentences for disobeying the laws. Imprisonment does not prevent the spread of HIV/AIDS. An exception might be if a person purposely or maliciously transmits HIV with the intent to harm others.<sup>32</sup>

## 1.9

### **Marginalised groups and the right to health**

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The right to health requires governments to pay special attention to marginalised and vulnerable individuals and groups, such as children, women and persons with disabilities. States should identify the barriers that prevent such people from realising their right to health and ensure that they have equal access to health care facilities, goods and services.

Marginalised groups have a greater burden of ill health than non-marginalised people. Discrimination and stigma increase vulnerability to ill health and limit the effectiveness of health interventions. The impact is worse when an individual suffers double or multiple discrimination on the basis of, for example, gender, race, poverty and health status.

In order to ensure that these groups have equal access to health care, States must gather disaggregated data based on these grounds in order to build a complete picture of the discrimination and to develop effective strategies to end it.

### 1.9.1 Women

According to the WHO Africa Director, Dr. Luis Sambo, women's health is crucial for development. Women's multiple roles include bearing and bringing up children, caring for the sick, providing food and taking part in the life of the community. They work longer hours than men. But instead of being empowered to play their multiple roles, many, according to Dr. Sambo, are "victims of socio-cultural discrimination, harmful practices (...) and gender-based violence."<sup>33</sup> They also face discrimination in relation to access to health services and to the underlying determinants of health. States have an obligation to ensure equal access of men and women to the enjoyment of all rights, including by ensuring equality and non-discrimination in areas such as political rights, marriage and family, employment and health.

#### **Violence against women and men**

*Violence against women* is pervasive but receives very little recognition. According to WHO (2002), one out of four women is likely to face violence, and one out of three adolescent girls reports that their first sexual experience was forced. Violence against women and girls includes physical, sexual, > psychological, and economic abuse (when someone, usually a man, takes control of another person's access to economic resources).

Violence against women and girls includes:

- Rape or sexual harassment, within marriage or dating relationships or by others;
- Beating or 'wife battering';
- Rape as a measure of punishment, for example when a girl has presumably showed unacceptable behaviour, like drunkenness;
- Systematic rape as a weapon during armed conflict;
- Forced or early marriage, or cohabitation, including the cultural practice of abducting young girls for courtship and marriage;
- FGC;
- forced virginity checks; and
- Forced prostitution and trafficking of women and children.

*Violence against men and sexual minorities* also receives little recognition. Recent studies show that men and boys experience sexual violence particularly in conflict situations and in prisons, boarding schools and military academies. Research carried out in nine provinces in South Africa showed that "almost ten percent of South African men have experienced some type of sexual violence by another man", and that perpetrators as well as survivors of male-on-male sexual violence were more likely to be HIV positive.<sup>34</sup>

Sexual violence is a profound health problem, sapping the victim's energy, compromising their physical health and eroding their self-esteem. It exposes them to a range of physical and mental health problems.<sup>35</sup> Sexual violence can cause injuries and death. All this severely limits the victim's contribution to social and economic development.

Many women are still unaware of their right to report abuse to a doctor, to the police or to women's groups. Even informed women are frightened of further violence if they report abuse. In some societies violence against women may be legitimised by traditional beliefs.

The right to participate is described in the Main Book, Part I, Section 6.5.

Some African governments have started to introduce domestic violence acts. However, there is a need to enforce existing acts and to involve traditional leaders in campaigns to change negative attitudes and cultural values.

There is a growing awareness that, in order to break the circle of violence, men should be targeted in gender-based violence interventions, both as perpetrators and victims. Many women, both survivors of domestic violence and those who provide services to women, suggest that domestic violence cannot be eliminated if interventions are solely aimed at women.

### 1.9.2 Infants, children and adolescents

Children, especially infants, are exposed to multiple risks. Many die before their fifth birthday, often because they are malnourished. Children and adolescents have less power than adults to defend themselves against violations of their rights.

The ICESCR, the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (African Child Charter) direct States to provide essential health services for children and their families. This includes pre- and post-natal care for mothers. States are required to take measures to reduce infant mortality and promote the healthy development of infants and children. They must also ensure that both children and those who care for them are taught how to protect children's health.



There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, FGC, and the custom of giving better food and care to male children (see Box 8).

**Box 10: Birth registration and health**

Article 6 of the African Child Charter states that: *“1. Every child shall have the right from his birth to a name” and “2. Every child shall be registered immediately after birth.”*

Registration at birth is crucial to the health and well-being of children. It is essential for prosecuting people who employ children in unhealthy labour, force them into marriage or recruit them into armed forces before they reach the minimum age for these situations. This can severely undermine their physical and mental development.

In some countries, proof of age is necessary to enter education or access health services. Birth registration provides the government with statistics on the numbers and ages of children. This allows them to plan for the provision of education, health, social welfare and other services. Of course, deaths should also be registered.

**1.9.3 Older persons**

Older persons require an approach that combines strategies to prevent ill health and to provide treatment and rehabilitation. This includes periodical check-ups for both sexes and treatment for physical and > psychological rehabilitation. Older people should be helped to maintain their independence as long as possible.

The African Women’s Protocol, Article 22, requires States to: “provide protection to elderly women and take specific measures [to address] their physical, economic and social needs as well as their access to employment and professional training.”

**1.9.4 Persons with physical and mental disabilities**

People with disabilities include those who have “long-term physical, mental, intellectual or sensory (sight or hearing) impairments” (Article 1 of the UN Convention on the Rights of Persons with Disabilities). They are among the most neglected and the most “invisible” in our communities. They experience various forms of discrimination including the denial of health services. They often experience human rights violations while in the care of mental health institutions, or in orphanages or prisons.

Article 25 of the Convention says that such persons should have “the same range, quality and standard of free or affordable health care and programmes as provided to other persons”. These services should be available in their communities.

For more information on the right to mental health, see Section 1.6.

### **1.9.5 Indigenous peoples**

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Indigenous peoples have the right to specific measures to improve their access to health services and care. These services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they are as user-friendly as possible.

Indigenous peoples protect their health by using medicines made of specific plants, animals and minerals. Their access to these items should be protected. Development-related activities that lead to the displacement of indigenous peoples against their will separates them from their traditional territories and environment, denies them their sources of nutrition and has a negative effect on their health.

### **1.9.6 Migrants**

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Migrants' right to health is often limited by discrimination, language and cultural barriers, or their legal status. Undocumented or "irregular migrants" and migrants held in detention are particularly at risk. States parties to the relevant treaties have an obligation to respect the right of non-citizens to an adequate standard of physical and mental health: they should not deny or limit their access to health services.

### **1.9.7 Prisoners and others living in institutions**

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People held in prisons or other institutions, such as asylums, are often held in overcrowded and unhealthy conditions. Many do not receive the medical attention they need.

Governments should ensure that living conditions comply with the UN Standard Minimum Rules for the Treatment of Prisoners. These set down the minimum requirements for protecting prisoners' rights to physical and mental health including: adequate sanitary conditions (Rule 12), nutritious food (Rule 20.1), drinking water (Rule 20.2), hygiene facilities (Rules 10, 13, 14) and medical services (Rules 22-26).

## 2 Preparing to take action

This section describes the elements to be considered before taking action to realise the right to the highest attainable standard of health. These elements reflect the basic principles of the human rights-based approach to development, or HRBA (see the Main Book, Part I, Section 6.4). Central to this approach is an understanding of what human rights violations are and the obligations that governments have to respect, protect, and fulfil these rights.

This section describes the following:

- Identifying government obligations to realise health rights;
- Understanding the role of non-State actors;
- Identifying health rights violations;
- Identifying relevant national laws and policies; and
- Developing strategies for action.

### Box 11: People's Health Movement and Right to Health Campaigns in Benin

The International People's Health Movement (PHM) has chapters in various countries including several in Africa.

The Benin chapter, for example, launched a Right to Health Assessment in March 2008. It decided to focus mainly on health access for all, including low cost drugs for tuberculosis and malaria, and reproductive health advice services for youth in rural areas. By 2010 the chapter had held public hearings to find out about people's experiences of their health services and completed a report on the country's right to health situation. It then prepared an action plan and made recommendations to the government on how to fulfil its obligations under the right to health.

In its January 2010 update on the country campaigns, the PHM Steering Committee noted a general problem: the recommendations in various country reports were not based on the principles contained in the human rights instruments which States have agreed to uphold.

Source: [www.phmovement.org](http://www.phmovement.org) and [www.phmovement.org/en/node/2769](http://www.phmovement.org/en/node/2769).

## 2.1 Identifying government obligations

Section 1.2 considered some government obligations concerning the right to health. This section gives more information about these obligations. More details can be found in CESCR's General Comment No. 14 and the Office of the High Commissioner for Human Rights Fact Sheet No. 31 on the Right to Health.

See also the Main Book, Part I, Section 4 and Appendix 2.

### Box 12: The Africa Health Strategy (2007-2015)

The Africa Health Strategy sets out a mission, a vision and a set of principles for African governments to follow. These are very briefly summarised here:

- **Vision:** freedom from the heavy burden of disease, disability and premature death.
- **Mission:** to strengthen health systems and empower communities.
- **Principles** include:
  - Health is a human right;
  - Effectiveness and efficiency is central to realising the maximum benefits from available resources;
  - Respect for culture and overcoming barriers to accessing services;
  - Prevention is the most cost-effective way to reduce the burden of disease;
  - Diseases know no borders – countries should cooperate; and
  - The health system should reach the poor and those most in need of health care. This will contribute to poverty reduction and overall economic development.

The strategy also gives practical advice about developing a national health strategy, including on finance, human resources and health system operation.

Sources: [www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA\\_HEALTH\\_STRATEGY.pdf](http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf); and [www.africa-union.org/.../AFRICA\\_HEALTH\\_STRATEGY.pdf](http://www.africa-union.org/.../AFRICA_HEALTH_STRATEGY.pdf)

### 2.1.1 Obligation to take steps

Steps to realise the right to health must be deliberate, concrete and targeted towards the full realisation of the right. This requires States at a minimum to adopt a national strategy based on human rights principles.

As with other rights, backward steps should not be taken. If a State does move backwards it has the obligation to prove that it has fully considered all alternatives (see the Main Book, Part I, Box 14).

### 2.1.2 Obligation to respect

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Under the obligation to respect the right to health, States must:

- Refrain from denying or limiting equal access to health facilities, goods and services. This applies to everyone, including prisoners or detainees, minorities, asylum seekers and illegal immigrants; and
- Abstain from discriminatory practices including those that relate to women's health status and needs (see Section 1.3.2 on equality and non-discrimination).

### 2.1.3 Obligation to protect

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Obligations to protect include the duties to:

- Adopt legislation or other measures to ensure equal access to health care and health-related services provided by private health care providers;
- Ensure that privatised health care providers do not undermine the availability, accessibility, acceptability and quality of health facilities, goods and services;
- Control the marketing of medical equipment and medicines by third parties;
- Ensure that health professionals are well trained and behave ethically (see Section 1.4.2); and
- Ensure that people have access to remedies, including through the courts, if their rights are violated (see Section 2.2).

Health care may be provided by the State or by private companies or NGOs. Under the obligation to protect, States must regulate the work of private providers. Both State and non-State providers must be required by law to ensure that health goods and services, including services related to the underlying determinants of health, must be affordable for all, including socially disadvantaged groups and people with disabilities.

#### Box 13: Medical councils

Medical councils are bodies set up by law to maintain high medical standards. Council members are usually qualified professionals elected by other medical practitioners.

A medical council's duties include:

- Keeping a register of medical practitioners (doctors, nurses and other skilled staff);
- Seeing that practitioners have the necessary skills;
- Ensuring that practitioners act according to a code of medical ethics; and
- Disciplining or dismissing those that do not meet the required standards.

There is an Association of Medical Councils in Africa (AMCOA). (No website available)

#### 2.1.4 Obligation to fulfil

The obligation to fulfil requires States parties to:

- Give sufficient recognition to the right to health in the national political and legal systems, preferably by making and implementing laws;
- Adopt a national health policy with a detailed plan for realising the right to health. The plan should ensure that health is linked to other relevant sectors such as education and infrastructure (building of health facilities, roads, etc.);
- Ensure equal access for all to the underlying determinants of health, such as food that is nutritious, safe drinking water, adequate sanitation and adequate housing and living conditions;
- Prioritise the needs of vulnerable and marginalised groups;
- Ensure provision of health care, including immunisation programmes against the major infectious diseases;
- Provide access to health information so that people can make informed choices and adopt healthy lifestyles. It should include information about nutrition, harmful traditional practices and the availability of services; and
- Develop systems to encourage community participation in health provision.

The right to participate is described in the Main Book, Part I, Section 6.5.

#### 2.1.5 Core obligations

According to the CESCR General Comment No. 3 on the Nature of States Parties Obligations, the national public health strategy and plan of action should cover the core obligations to provide:

- Essential primary health care (see Section 1.3.2);
- Access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- Access to the minimum essential food which is nutritionally adequate and safe, so that no one suffers from hunger;
- Access to basic shelter, housing and sanitation, and an adequate supply of safe drinking water;
- Essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; and
- Fair distribution of all health facilities, goods and services.

#### 2.1.6 Our obligations to protect our own health

Governments have obligations to realise the right to health, but they cannot do this alone. Everyone except small children and others who need special care has a responsibility to take care of his or her own health. They should, for example: avoid sweets and fizzy drinks that rot one's teeth; refrain from driving after drinking alcohol; and wash their hands before eating. NGOs can play a crucial role in spreading knowledge about health care.

### 2.1.7. The right to health in national and local legislation and policies

In order to work on health rights it is essential to obtain information about laws and policies related to the right to health. African States are increasingly including the right to health in their constitutions, national laws or policies. This enables courts and other national accountability institutions to uphold people's health rights.

A country's constitution may allow other levels of government to make laws. However laws made at the provincial or local level should not contradict the constitution and the national law. Under some constitutions, traditional leaders have powers to make decisions on matters such as land use, agriculture and health. They can also play an important role in promoting the right to health. For example in addressing sexual and gender-based violence (see Section 1.9).

#### Box 14: The right to health in some African constitutions

**Uganda:** The Constitution (1955) refers to health under the Directive Principles of State Policy.

Article XIV (b) states that “all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.”

Article XX says that: “The State shall take all practical measures to ensure the provision of basic medical services to the population.”

**South Africa:** Article 27 of the Constitution (1996) states:

“Health care, food, water and social security.

- (1) Everyone has the right to have access to:
  - (a) health care services, including reproductive health care;
  - (b) sufficient food and water; and
  - (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.”

A few States, such as Angola and South Africa, have a national health law that applies to the health system as a whole. More often, States have laws or policies on specific aspects of health. For example, several West African countries including Chad, Guinea and Mali, have laws on family planning and reproductive health.

### 2.1.8 Where to find laws and policies

Health laws and policies may be found on a country's website of the Ministry of Health and other relevant ministries.

In addition to looking at the constitution, laws, and policies, other places to find information are:

- The treaties that the State has ratified or acceded to;
- WHO Country Cooperation Strategies;
- International and regional declarations, resolutions and programmes supported by the State such as the Africa Health Strategy;
- Constitutional provisions and laws on health and the underlying determinants of health including safe water and sanitation. Even if there is no specific right to health in national law, lawyers may be able to take up cases under other laws concerning, for example, the protection of the family or preserving a healthy environment;
- Regulations on health, including rules for non-State service providers;
- Provincial and local laws that should be available in local government offices;
- Traditional laws: consult traditional leaders and elders in the community;
- Ministries or departments responsible for health and the underlying determinants of health. Relevant ministries may be those for food, agriculture, social services, rural development and local communities;
- > Demographic and health surveys that gather disaggregated data on the main causes of illness and death in the population;<sup>36</sup>
- The websites of medical councils, nursing associations and medical universities or colleges;
- Local governments or municipalities that have powers to provide or regulate health services;
- Budget allocations for health and the underlying determinants of health;
- Reports, news articles, NGO publications, UN reports, and academic articles and websites;
- Relevant local and national accountability mechanisms such as human rights commissions; and
- National Millennium Development Goals (MDG) reports. These contain information about progress towards the health goals, Goals 4, 5 and 6 (see: [www.undg.org/index.cfm?P=87&f=A](http://www.undg.org/index.cfm?P=87&f=A)).

## 2.2 Enforcing the right to health at the domestic level

According to the Africa Health Strategy, “Health is a human right that is increasingly being recognised as enforceable, for example by a court. Governments have a responsibility for guaranteeing health care for all their citizens in an equitable [fair] manner and with responsible and efficient governance, while using resources accountably”.

The right to health requires that States are accountable. States must set up effective, transparent and accessible monitoring and accountability mechanisms. People must have a right to a remedy if their health rights are violated.

**Box 15: The role of courts**

In some countries, courts have used constitutional provisions or laws to reinforce the right to health. A relevant example is the decision of the Constitutional Court of South Africa in *Minister for Health v. Treatment Action Campaign (TAC)*.

This case concerned State provision of Nevirapine, an antiretroviral drug used to prevent mother-to-child-transmission of HIV. The drug was available at only two research and training sites in each province or from private medical providers. As a result, mothers who did not have access to the research and training sites, and who could not afford private health care, were unable to use Nevirapine. The government said that it could not provide the drug more widely. However, the Constitutional Court held that this was unreasonable. It ordered the government “to devise and implement a comprehensive and coordinated programme to realise progressively the right of pregnant women and their newborn children to have access to [Nevirapine] to combat mother-to-child transmission of HIV”.

Such cases, whether at the national, regional or international levels, confirm that the courts have an important role to play in the protection of the right to the highest attainable standard of health (see also Box 35 in the Main Book, Part II).

Any person or group experiencing a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.

National accountability institutions:

- **The courts:** where laws or policies have been established, courts can impose criminal or civil penalties on public officials and private persons who fail to comply with the law. They can also require the government to change laws or policies;
- **Human rights commissions and ombudsman institutions** can usually act on complaints from members of the public and review health policies;
- **Human rights > impact assessments.** These may be carried out before a project, for example to build a chemical factory, to see what impact this may have on people’s health. One should have been carried out in the Ogoni case in Nigeria (see Box 16);
- **Parliamentary health committees** exist in many countries. They may have the power to carry out inquiries and to call the Health Minister to account for her or his actions;
- **Medical councils and nursing councils** register medical doctors and nurses and ensure that they are properly qualified and meet certain standards (see Box 13); and
- Some **health councils** at State and municipal levels allow members of the public to participate in meetings to give their opinions and contribute to the health policy.

For more on remedies for ESC rights violations, see the Main Book, Part I, Section 4.7.

## 2.3 Regional human rights law and accountability institutions

The right to health is recognised in:

- The African Charter on Human and Peoples' Rights (Article 16);
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Article 14);
- The African Charter on the Rights and Welfare of the Child (Article 14);
- The African Youth Charter (Article 16); and
- Various treaties of the AU that protect the right to a healthy environment.

In Africa, the accountability institutions include the African Commission, the African Court of Human and Peoples' Rights and some sub-regional courts (see the Main Book, Part I, Section 6.2). At the international level, the CESCR can take cases of violations of the right to health.

### Box 16: The Ogoni case

Members of the Ogoni community in Nigeria alleged that the military government had violated their rights to health and a clean environment by allowing oil companies to contaminate soil and water, leading to serious and widespread health problems among the Ogoni people. The African Commission found that the government had failed to adequately regulate and monitor the oil companies. It issued a number of orders, for example, that any further oil development should be monitored by effective oversight bodies and health and environmental information should be made available.

This case is also mentioned in the Haki Zetu handbooks on Housing and Food.

Source: Decision Regarding Communication 155/96 (Social and Economic Rights Action Center/Center for Economic and Social Rights v. Nigeria). Case No. ACHPR/COMM/A044/1.

### 2.3.1 The role of the African Commission

The African Commission has made recommendations to States concerning government obligations to uphold the right to health. Such recommendations are part of the Commission's regular monitoring of States under the reporting system (see the Main Book, Part I, Section 3.5). It can also receive complaints about violations of the right to health.

**Box 17: The African Commission and the right to health**

**The Gambia:**

In 2001 the African Commission found that The Gambia had violated Article 16 of the African Charter by detaining people in mental asylums without proper diagnosis and in appalling conditions.

Source: African Commission on Human and People's Rights, Communication 241/2001 – Purohit and Moore, The Gambia.

**Sudan:**

In 2004, after receiving a complaint about human rights violations in Darfur, Sudan, including forced evictions and the bombing of water supplies, the Commission carried out a fact-finding mission to Darfur. In 2009 it ordered Sudan to “rehabilitate economic and social infrastructure, such as education, health, water, and agricultural services, in the Darfur provinces in order to provide conditions for return in safety and dignity for the IDPs (internally displaced persons) and Refugees”.

Source: *African Commission on Human and People's Rights*, Communication Nos. 279/03 & 296/05 (2009).

## 2.4 The role of non-State actors

States have the primary responsibility for ensuring the right to the highest attainable standard of health. However, it is a shared responsibility. All members of society have responsibilities towards realising the right to health. This includes individuals, health professionals, families, local communities, intergovernmental and non-governmental organisations, civil society organisations, and private businesses (see Section 2.1.3).

The MDGs, for instance, recognise that > pharmaceutical (drug) companies are among those sharing this responsibility. Goal 8, a global partnership for development, has a number of targets, not least: “In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries”.

A State's obligation to protect human rights includes ensuring that non-State actors do not abuse human rights. With respect to health, States should, for instance, adopt laws or other measures to ensure equal access to health care provided by third parties such as NGOs and private health care providers.

The MDGs aimed to halve the number of people living in poverty by 2015. For more information, see Appendix 4.

Companies selling pharmaceutical products or medical equipment may contribute positively to the enjoyment of the right to health, but they may also make health care more difficult to access or afford. In South Africa, civil society groups took action to make costly drugs available to people living with HIV/AIDS (see Box 15).

Non-State actors include traditional authorities, some of whom allow harmful traditional practices to continue.

## 2.5 Case study: Identifying violations of the right to health

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Violations of the right to health are not always easy to identify. Care must be taken to point out exactly how the State failed to carry out specific human rights obligations.

For more information on identifying human rights violations, see the Main Book Part I, Section 4.6.

Human rights violations take place when governments fail to respect, protect or fulfil rights because of:

- Unwillingness;
- Negligence; or
- Discrimination.

### **Aziza's case**

This case study, which describes the situation faced by women in many countries, shows the process of analysing a situation in order to determine:

- Whether the government has failed to meet a specific obligation and, if so,
- Whether this amounts to a human rights violation.

Aziza was 39 years old and lived in a small rural community. She had five children and worked hard to support them. Food was scarce and Aziza became malnourished and anaemic (weak). Although she did not want another child she became pregnant again. She had never been told about reproductive and maternal health or family planning. There was no health post in the village. When the baby started to come, Aziza began bleeding heavily. Neither the traditional birth attendant nor her mother-in-law recognised the seriousness of the problem. Aziza collapsed. The nearest hospital was 15 kilometres away. The family could not afford to pay for transport or health fees so they borrowed money. When they reached the hospital they were told that the hospital did not have the medical equipment and drugs that Aziza needed. Both Aziza and her baby died.

### **1. Identify violations of the right to health**

- Refer to the elements of the right to maternal health (Section 1.5) and identify the problems that lead to maternal and infant mortality;
- Identify the factors that led to the death of Aziza and her baby:
  - Aziza's age and the fact that she already had five children;
  - She was undernourished and anaemic;
  - She had no knowledge of family planning or of reproductive and maternal health;
  - There was no skilled birth attendant to assist her;
  - The nearest medical facility was far away and time was lost raising money for transport and fees; and
  - The medical facility did not have the necessary equipment and drugs.

### **2. Review the government's obligations** (Section 2.1).

Assess whether the government may be accused of failing to:

- Provide adequate maternal health facilities, goods and services (see Section 1.4);
- Attend to the underlying determinants of health (see Section 1.4 and Figure 2 in Section 1.2.2);
- Invest in programmes to raise awareness of sexual and reproductive health rights;
- Take concrete, targeted steps to realise the right;
- Provide information and opportunities for residents to participate in decision-making regarding the quality and provision of services (see Section 2.1.4); and
- Uphold other human rights including the right to education.

### **3. Identify the national laws and/or policies that apply** (see Section 2.2)

- Do the policies show how the government is planning to extend health care to rural areas?
- What information about maternal mortality rates is provided? Are there statistics relating to the district or local levels? Does this information show discrimination in favour of cities or areas where richer people live?
- What are the main causes of maternal mortality reported in the census or demographic health data? Does the government have plans and projects to deal with these? (See Section 1.5)
- What is the condition of maternal health care services in the area? Are they adequately staffed and equipped?
- Is there a system for making a complaint about health services? (See Section 2.2)
- What has the government done to provide or improve maternal health services?

### **4. Identify actions or omissions that may amount to right to health violations and explain the violation clearly** (see Section 1.2.3)

- What national law (if any) has been broken and how?
- What regional and international standards apply?
- Which human rights obligations has the government failed to carry out?

- Under which article of the law or treaty?
- Refer, as appropriate, to General Comment 14 or other sources in Appendix 1 or to relevant decisions of national courts or accountability mechanisms.

Assessment: write up your own decision on the case study and discuss it with others.

## **2.6** Identifying and planning strategies for action

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The Planning Box at the end of the Main Book, Part II outlines the steps necessary for identifying and planning strategies for action. These steps are:

- Stage 1: Identify the problem(s), setting goals and objectives;
- Stage 2: Develop a plan of action;
- Stage 3: Gather information;
- Stage 4: Claim and defend ESC rights; and
- Stage 5: Evaluate the project and develop a follow-up plan.

CSOs working on the right to health can follow these steps when deciding on the types of actions to undertake to realise right to health.

# 3 Actions to realise the right to health

This section suggests ways to work with communities to realise the right to health. See also the Main Book, Part II, Section 3.

Different types of actions include:

- Raising awareness on the right to health;
- Monitoring the implementation of health policies and projects, identifying right to health violations and bringing these to the attention of the authorities;
- Practical actions to prevent disease and promote better health;
- Supporting community groups to advocate for appropriate policies and laws on health; and
- Participation in policy development.

The actions described in this section correspond with the right to health issues explained in Section 1. This section contains checklists and other tools for monitoring and investigating specific aspects of the right to health. It also makes suggestions for other actions to claim and defend the right to health.

## 3.1 Before taking action

Many aspects of the right to health are difficult for non-professionals to understand.

NGOs and CBOs should take advice from professionals if they are in any doubt about what action to take. Wherever possible, they should work together with local or community health workers.

First, however, it is advisable for NGOs and CBOs working on the right to health to gather some basic information about the right to health in their community. This includes:

- Gathering general information on the main health problems in the area;
- Finding out what health facilities are available;
- Seeking information about the role and responsibilities of the local health service; and
- Looking at the relevant national, provincial, local and traditional laws, and international treaties if ratified by the country in question.

If it is difficult to find information, consider joining with others to press the authorities to respect the right to information (see the Main Book, Part I, Section 6.5).

### 3.2 Raising awareness of the right to the highest attainable standard of health

When people are well aware of their rights, governments are more likely to fulfil their obligations. Advice on raising awareness is given in the Main Book, Part II, Section 11.1.

There are two kinds of awareness-raising. One focuses on helping people to analyse their health problems in order to understand them. Another shows health conditions through a human rights lens. This gives a deeper understanding and leads to action to realise rights. Familiarity with national laws and policies empowers people to claim the rights they are entitled to. Often those in charge of implementing health policies are not familiar with the contents of these documents. So educating the public as well as the local implementers is crucial for policies to reach the local level.

During awareness-raising activities, it may be useful to keep notes of what people know and gaps in their knowledge. This will help in the planning of further awareness-raising activities.

**Note:** The government has an obligation to provide health education. This involves ensuring that the public is informed about such things as health hazards, publicising immunisation campaigns, and promoting healthy behaviour, such as stopping smoking. The government should also publicise and educate people on existing national laws and policies. CSOs should monitor the government's health information programme and draw attention to gaps and failures.

#### 3.2.1 Raising awareness among the community

Awareness-raising could start with involving community members in analysing a particular health issue. This could lead to a discussion about the underlying determinants and government obligations. The discussion could move on to people's rights and how they can claim them.



### 3.2.2 Raising awareness among the general public

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This can be achieved through activities such as participatory theatre (see the Main Book, Part II Section 11.6.4), holding public debates or using the communications media, particularly the radio.

CSOs can also carry out campaigns to make people aware of their rights in relation to specific health topics such as water-borne diseases, malnutrition or infant mortality.

See the Main Book, Part II, Section 11.4. The booklets on the rights to adequate food and to water and sanitation provide some additional ideas.



### 3.2.3 Raising awareness among health officials

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CSOs working on the right to health and health professionals can learn from each other.

Building a relationship with health professionals, both in the public and private sectors, could start with asking health professionals to give advice on medical matters and on how CSOs could contribute to improving people's health.

Professionals could learn from CSOs about the value of using a human rights-based approach. Often health professionals are not aware of existing national policies. Educating them about these could help in implementation.

Another approach may be to involve health professionals in planning and holding your awareness-raising activities. Health professionals could also be invited to take part in awareness-raising or other activities.

Raising awareness of the right to health should be linked to specific situations. Some examples are given in Table 1.

**Table 1: Topics for awareness-raising**

Situation	Target/s	Topic	Project / activity to:
Lack of awareness about family planning	Men and women, youth, health officials, government officials	The right to access to family planning	Survey to find out what people think or know about family planning. Hold an information meeting involving health workers.
Government polio eradication campaign	Parents	The right to health care and access to medicines	Ensure that parents and other community members participate in planning and implementing the campaign.
Environmental health hazards	Agricultural company	The right to a healthy environment	Document health hazards and produce a report.
Gender discrimination	Health officials	Right to equality	Document gender discrimination, publicise findings and recommend changes.
Harmful traditional practices and medicines	Men and women, youth, government officials, practitioners	The obligation to end traditional practices harmful to health. The obligation to protect people against unsafe medicines.	Work with communities to find appropriate ways to raise awareness of the dangers of using traditional medicines that have not been scientifically tested. Explain the human rights implications of harmful traditional practices (see Box 8).

**Box 18: Raising awareness about HIV and AIDS in Nigeria**

The Mothers' Welfare Group (MWG) is based in Kaduna, Nigeria. Among other activities, it supports HIV and AIDS orphans and vulnerable children and their families. Assisted by Healthlink Worldwide, a UK-based NGO, it uses drama to raise awareness about HIV and AIDS. It also provides parents with the knowledge and skills they need to support their children. Another activity is training health workers on the prevention of the spread of HIV and AIDS.

Sources: [asksource.ids.ac.uk](http://asksource.ids.ac.uk) and [www.healthlink.org.uk/projects/hiv/ovc.html](http://www.healthlink.org.uk/projects/hiv/ovc.html).

### 3.3 Monitoring the right to health

In order to realise the right to health, the State has a duty to monitor the population and its state of health. Many States do this by carrying out “demographic and health surveys” (DHS). These should be available on the government website.

They may also be available on:

- The Measure DHS website at [www.measuredhs.com](http://www.measuredhs.com); or
- The WHO website at [www.afro.who.int/en/countries.html](http://www.afro.who.int/en/countries.html).

The monitoring activities of CSOs can make a significant contribution to improving access to health care. They can find out whether rights are being upheld and whether policies are implemented at the local level and have the intended impact. The information they gather can encourage States to make the most effective use of limited resources. Various actions for monitoring the right to health are given below.

#### Box 19: Health Rights of Women Assessment Instrument (HeRWAI)

A tool for assessing health rights, specifically of women, is HeRWAI (Health Rights of Women Assessment Instrument). It consists of 6 steps, with a set of questions in every step. All steps need to be analyzed in a joint effort between different actors, including if possible governmental actors. In the last step, recommendations and an action plan are formulated to advocate for the improvement of (women's) health rights. A HeRWAI analysis links what actually happens with what should happen according to the human rights obligations of a country.

The tool can be accessed at [www.humanrightsimpact.org/themes/womens-human-rights/herwai](http://www.humanrightsimpact.org/themes/womens-human-rights/herwai) or [www.rights4change.org](http://www.rights4change.org).

#### 3.3.1 Monitoring access to health care facilities, goods and services and underlying determinants of health

This section contains two checklists: one on monitoring access to facilities, goods and services and another to monitor the underlying determinants of health.

**Box 20: How to use checklists**

Checklists should be used in collaboration with members of the community, following the advice in the Main Book, Part II, Section 5.

**Note that:**

- The checklists do not cover every situation nor do they cover every aspect of a situation, so you may have to adjust them to your own circumstances. Sometimes you may need to use two checklists or only part of a checklist. You could also use a checklist in combination with other monitoring tools (tables) in this section;
- The checklists contain many tasks. These may be carried out in stages or selected according to the situation;
- They do not have to be carried out in any particular order;
- All monitoring should take into account the different situations and needs of women and girls;
- Whenever possible, before carrying out any project, monitors should seek initial advice from health professionals. Professional advice is also needed for some specific aspects of monitoring; and
- The checklists contain references to the Main Book, Part II, where necessary.

Use Appendix 1 to find relevant extracts from regional or international human rights standards. These are useful for deciding how to formulate questions and also for pointing out government obligations.



# Checklist 1. Monitoring health facilities, goods and services



## Objectives:

- To assess the availability, accessibility, acceptability and quality of health facilities, goods and services; and
- To ensure marginalised groups have equal access to these facilities, goods and services. (See also Section 1.4 of this handbook)



## Tasks

Check

### 1. Participatory research into health care needs of the community

- Carry out interviews or surveys to find out about people’s health care needs .....
- Pay special attention to vulnerable or marginalised groups and collect disaggregated data that reflect the situation and the different types of disabilities faced by each group such as rural women with disabilities (see the Main Book, Part II, Boxes 24 and 25) .....
- Refer to the government’s demographic and health survey and other information such as WHO country health information to identify disease patterns .....
- Map the health care needs of the community in collaboration with community health workers and village level health teams (Main Book, Part II, Section 4.2) .....
- Identify the specific health care needs of these groups .....

**Note:** Information about individuals should be treated as confidential (Main Book, Part II, Section 8.2).

### 2. Monitoring the availability, acceptability and quality of health facilities, goods and services

#### 2a. Monitoring AVAILABILITY of health facilities, goods and services (see Section 1.4.2)

Map the health facilities in the area. Note the services they provide and whether these are provided by the State or by non-State actors. Services should include:

- Emergency services .....
- Appropriate treatment for common diseases and injuries .....
- Sexual and reproductive health services (see Section 1.5) including:

- Family planning .....
- Skilled birth attendants .....
- Emergency childbirth care (see Section 1.5.4) .....
- Child care .....
- Mental health services .....
- Immunisation against major infectious diseases, including HIV/AIDS, malaria, > meningitis and tuberculosis (TB) .....
- Programmes for the prevention, treatment and control of diseases .....
- Essential medicines as defined by the WHO (see Section 1.8.4).....
- Health awareness and education programmes .....
- Environmental health programmes .....

**Note:** If possible, ask a health professional for advice about how to obtain the following information:

- How many doctors and nurses work in each facility .....
- What training they have had .....
- Whether they have adequate working conditions and salaries .....
- If they have adequate equipment such as X-ray and blood-transfusion units .....
- If there are adequate supplies of essential medicines .....
- If health facilities have integrated referral systems (systems to refer patients to other parts of the health system for appropriate attention) .....
- Whether staff speak the local language .....
- Identify any gaps in availability, for example, facilities may be concentrated in one area, leaving other areas with few available facilities .....

**2b. Monitoring ACCESSIBILITY of health facilities, goods and services**

Carry out participatory surveys to find out:

- Whether health goods, facilities and services are available without discrimination on any of the prohibited grounds (listed in the Main Book, Part I, Section 4.3, first paragraph) .....
- How easy or difficult it is for people to reach the services on foot or using public transport .....
- Length of waiting times at health facilities .....
- If people can afford health care without having to give up other essentials such as food .....
- Whether health care is accessible to people with physical, sensory (sight, hearing) and mental disabilities (obtain disaggregated statistics) .....
- Whether information about health and health care is available and accessible to all, including those who cannot read or who speak other languages. The same question applies to health education .....
- If people can make complaints (identify relevant accountability institutions, try to get the number of complaints and remedies received) .....
- Whether people have the opportunity to participate in decision making .....

**2c. Monitoring ACCEPTABILITY of health facilities, goods and services**

Interview health officials, health staff and patients to find out whether health goods, facilities and services respect:

- The requirement of > informed consent for all medical treatment ..... ○
- The confidentiality of personal health information ..... ○
- The cultures of individuals, minorities, and communities ..... ○
- The needs of women, men, older persons and adolescents ..... ○

**2d. Monitoring QUALITY of health facilities, good and services**

Carry out research to determine whether health goods, facilities and services meet quality standards:

- Find out whether (and how often) the relevant authorities carry out inspections .... ○
- Health inspectors should have a checklist. Try to obtain copies of the checklists and an inspection report to find out what they cover ..... ○
- Hospitals should be safe, clean, and welcoming. Visit health facilities and interview members of the community to hear their views on:
  - The cleanliness of health facilities ..... ○
  - Length of waiting times for emergency cases and non-emergency cases ..... ○
  - Attitudes of the staff towards patients ..... ○
- Find out if patients have an opportunity to provide feedback so that hospitals can respond sensitively to their concerns ..... ○
- Find out if there are systems for gathering and sharing medical information and carrying out health-related research to improve health care ..... ○

**3. Analysing results and taking action**

The results of this exercise will be useful for actions on aspects of health rights set out in the following sub-sections of this booklet (see also the Main Book, Part II, Sections 1-3).

In collaboration with the community, decide which issues to tackle and carry out a SWOT analysis as described in the Main Book, Part II, Section 2.2.

Source: Based mainly on Paul Hunt and Gillian MacNaughton, *Impact Assessments, Poverty and Human Rights*, UNESCO, 2006.

### **3.3.2 Monitoring underlying determinants of health**

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The checklist gives further advice for monitoring the government's progress towards making the underlying determinants available, in sufficient quantity and quality, throughout the country. The main underlying determinants are:

- Safe drinking water;
- Food and nutrition;
- Safe housing with adequate sanitation facilities;
- Healthy workplace and natural environment conditions; and
- Access to health-related information and education.



## Checklist 2. Monitoring underlying determinants of health



### Objectives:

- To assess the availability, accessibility, acceptability and quality of underlying determinants of health; and
- To ensure marginalised groups have equal access to these determinants.



### Tasks

Check

#### 1. Gathering information on the underlying determinants of health (see Figure 2)

Gather information from:

- National laws and policies on relevant underlying determinants .....
- Demographic data which should show the main causes of illness and death in different groups .....
- Local health authorities .....
- Relevant budgets and planning documents .....
- Reports, news articles, NGO publications, UN reports, and academic articles and websites .....
- Relevant accountability institutions and find out what powers they have .....

#### 2. Identifying the impact of inadequate underlying determinants of health

In addition to the tasks given in Section 3.1:

- Identify one or two groups whose health is undermined by the lack of one or more underlying determinants such as food or clean water .....
- Identify one or two groups who do not suffer the same negative underlying determinants .....
- Develop a set of questions and interview a similar number of members from each group (see the Main Book, Part II, Sections 6.5 and 6.6 for advice on how to conduct interviews and surveys, which method to choose and how to carry out interviews sensitively) .....

For each group, find out:

- The main health problems in the area .....
- What the community members believe to be the causes .....
- If community members have identified solutions to the problems or received help from the authorities .....
- How many of the people questioned have suffered the health problems they have identified
- What was the impact of these problems on their lives .....
- Their experience of seeking health care .....

- Whether they reported their problems to the authorities (when and with what response) .....
- What did they do themselves? (self-help actions) .....
- What would they like the authorities to do .....
- The availability, accessibility, acceptability and quality of underlying determinants that the community has not mentioned (Ask why they have not mentioned these determinants) .....

**2a. Monitoring availability**

Find out if the local government facilitates access to the following resources in sufficient quantity:

- Safe drinking water .....
- Food and nutrition .....
- Safe housing with adequate sanitation facilities .....
- Healthy workplace and natural environment conditions .....
- Health-related information and education .....
- Any other underlying determinant of health .....

**2b. Monitoring accessibility**

Ask whether underlying determinants of health are accessible:

- Without discrimination on any of the prohibited grounds .....
- In terms of distance and physical accessibility, especially for those living in poverty or in remote areas .....
- For people with physical, sensory (sight, hearing) and mental disabilities .....
- Are services free? If user fees are charged, are they affordable? .....
- Do people receive information and education and the necessary resources that could help them understand and deal with the problem?.....

**2c. Monitoring acceptability**

Find out whether the underlying determinants respect:

- The cultures of individuals and communities .....
- The needs of women, men, older persons and adolescents .....
- Other aspects of daily living .....

**3. Analysing results and taking action**

- Discuss the results of the investigation with members of the community .....
- In a written report, summarise evidence of any violations of the right to one or more of the underlying determinants of health, explain clearly the relevant human rights obligations .....
- Carry out relevant actions described in the Main Book, Part II, Sections 1-3 .....

Source: Based on Paul Hunt and Gillian MacNaughton, *Impact Assessments, Poverty and Human Rights*, UNESCO, 2006.

### 3.4 Actions to improve access to sexual and reproductive health

Sexuality education and family planning are very relevant elements of the right to health, which are all based on the right of women and men to decide freely and responsibly what happens to their own bodies and lives, including whether and when to have children (see Section 1.5).

Awareness-raising is a key activity. Suggestions for awareness-raising were given in Section 3.2.2. Some additional advice is given below. Specific attention is given to the youth, who need it most.

This section also contains tools for monitoring and improving access to sexual and reproductive health care. Other organisations have developed tools and methods to assess and monitor other elements of sexual and reproductive health rights. Some of these are given in Appendix 2.

#### 3.4.1 Improving access to sexual and reproductive health for youth

The African Youth Charter is a useful tool for raising awareness about sexual and reproductive health for youth. Some provisions are given in Appendix 1.

NGOs and CBOs can encourage the authorities to ensure that health facilities are equipped to attend to young people and give them all necessary information and services related to sexual and reproductive health in a non-judgmental way. This includes:

- Ensuring that health personnel are trained in encouraging young people, including unmarried youth of both sexes, to access reproductive health services and ensuring that their privacy is respected; and
- Making young people aware of the dangers of unsafe abortion and, if necessary, lobbying the authorities to change any laws that prevent or restrict access to safe abortions and to ensure that safe abortion services are available and accessible.

The African Youth Charter, in Article 16 sub 2.i, calls on States to institute comprehensive programmes including legislative steps to prevent unsafe abortions.

NGOs could consider monitoring one or more of the following:

- The availability of information about sexual and reproductive health;
- The availability of condoms;
- The availability and accessibility of safe abortion services; and
- The effect of unsafe abortions on the maternal mortality rate in the area.

#### 3.4.2 Tackling harmful traditional practices

These should be tackled through dialogue with traditional service providers (e.g. circumcisers) and traditional leaders.

Harmful practices were described in Box 8.

The Population Council, an international NGO, has found that traditional leaders, both male and female, can play an important role in tackling gender-based violence, particularly through the traditional court system and awareness-raising.<sup>37</sup>

Practices such as harmful initiation rites can be replaced by alternative initiation rites that include useful educational lessons on sexual and reproductive health. For example, in Mali, mobile cinema (supported by UNICEF) has helped to reduce the incidence of FGC. The mobile cinema travels among villages in Mali. The facilitators show entertaining and educational films and then discuss the issues with the audience.<sup>38</sup>

Dialogue is also necessary to encourage bringing traditional laws on marriage into line with human rights and relevant national policies and laws.

#### Box 21: Assessing domestic violence policies

DOVA is a tool for analysing and evaluating policy on domestic violence. The DOVA assessment process has seven steps. Each step contains questions, examples and checklists to guide the data collection and analysis. The analysis results in recommendations for more effective law or policies that respect human rights, and an action plan to lobby for policy reform and to raise awareness about the findings.

The tool can be found at [www.humanrightsimpact.org/fileadmin/hria\\_resources/Domestic\\_Violence/DOVA-DEF-sept-2011.pdf](http://www.humanrightsimpact.org/fileadmin/hria_resources/Domestic_Violence/DOVA-DEF-sept-2011.pdf).

### 3.4.3 Monitoring maternal and infant mortality

Monitoring maternal mortality should be done by medical professionals. However, there are at least two kinds of simple monitoring that can be done by CBOs: monitoring the availability of emergency childbirth care and monitoring the “three delays” (see Section 1.5.4). The following tool (Table 2) gives suggestions for both kinds of monitoring. The results of this monitoring exercise will be useful for further actions aimed at reducing maternal and infant mortality.

#### Using the tool

Essential information is given in the left-hand column and the information-gathering tasks are in the right-hand column.

**Table 2: Monitoring access to emergency obstetric (childbirth) facilities**

1. Types of facilities and what they provide	Monitoring tasks
<p>For every 500,000 population, there should be:</p> <ul style="list-style-type: none"> <li>• At least 4 basic emergency childbirth facilities; and</li> <li>• At least 1 comprehensive emergency childbirth facility (see Section 1.5.4).</li> </ul>	<ul style="list-style-type: none"> <li>• Find out the number of people living in the area to be studied. The local authorities should have this information. If not, proceed to the next task.</li> </ul>
<p>A basic facility should be able to do the following:</p> <ul style="list-style-type: none"> <li>• Administration of parenteral antibiotics (those not given through the mouth);</li> <li>• Administration of oxytocic drugs (these make the uterus or womb contract and hasten the birth);</li> <li>• Administration of anti-convulsants to stop fits (involuntary jerking);</li> <li>• Removal of the placenta (the lining of the womb);</li> <li>• Removal of retained products (such as part of the placenta that may remain in the womb); and</li> <li>• Assisted vaginal delivery (when a surgical instrument is used to help the baby out of the womb).</li> </ul>	<ul style="list-style-type: none"> <li>• Check whether these services are available.</li> </ul>
<p>Comprehensive emergency childbirth care includes, in addition to services listed above:</p> <ul style="list-style-type: none"> <li>• Caesarean surgery (removing the baby by opening the womb); and</li> <li>• Blood transfusion.</li> </ul>	<ul style="list-style-type: none"> <li>• Check whether these services are available.</li> </ul>
2. Access to emergency childbirth care – people’s experience	Monitoring tasks
<p>All women should be able to access emergency childbirth care services.</p>	<ul style="list-style-type: none"> <li>• Carry out interviews to find out what women say about access to emergency childbirth services (see the Main Book, Part II, Section 6.6). Do they know about the services? Have they used them? What was their experience?</li> <li>• Interview community health workers and traditional birth attendants and find out what they think about access to emergency childbirth services; and</li> <li>• Summarise the responses in your report.</li> </ul> <p style="text-align: right;"><i>&gt; continued</i></p>

3. Monitoring the “three delays” (see Section 1.5.4)	Monitoring tasks
<ol style="list-style-type: none"> <li>1. Delay in seeking appropriate medical help for a childbirth emergency because of:                             <ul style="list-style-type: none"> <li>- Cost;</li> <li>- Failing to recognise the urgent need for medical attention;</li> <li>- Lack of information about the risk factors; or</li> <li>- The woman’s lack of authority within the family to make decisions.</li> </ul> </li> <li>2. Delay in reaching an appropriate facility because of distance, bad roads or lack of transport.</li> <li>3. Delay in receiving adequate care after reaching a facility owing to staff shortages, or lack of electricity, water or medical supplies.</li> </ol>	<ul style="list-style-type: none"> <li>• Interview women to find out if they, or other women they know, suffered from delay in reaching medical help. Identify the reason for the delay. For example, the woman’s husband may have advised against seeking medical attention;</li> <li>• Prepare a table listing the delays in the first column (see the delays in the column here on the left) and, in the second column give the number of people who experienced this type of delay. Also include the total number of women interviewed;</li> <li>• Write case histories and include them in the report (do not use names or details that could identify the women - see the Main Book Part II, Section 6.6 on prior consent and respecting confidentiality); and</li> <li>• Identify recommendations to make to the authorities.</li> </ul>

### 3.4.4 Raising awareness of maternal, sexual and reproductive health

One of the first tasks is to speak out about the shocking aspects of maternal mortality (see Section 1.5).

A related task is raising the awareness of both women and men about the risk factors, such as the mother’s age and the number of her children, cultural factors, the warning signs of complications, and the need to seek immediate medical help. This is the task of governments. CSOs can press the government to do this and also raise awareness themselves amongst the general public as well as amongst influential local leaders.

The following actions could be combined with actions suggested in Section 3.2:

- Raising awareness of the right to maternal health. Actions may be targeted at vulnerable groups, such as ethnic minorities, internally displaced people, refugees and people in rural areas. They should be targeted at men as well as women;
- Public hearings to allow people to speak of their experience of health services. See Box 11;
- Public meetings to discuss the government’s maternal and child health programmes and sexual and reproductive health policies, statistics and spending;

- Lobbying the authorities to provide culturally sensitive comprehensive sex education programmes aimed at increasing understanding about family planning, sexuality and respectful sexual relationships; and
- If birth registration is available, make parents aware of the importance of registering births. If not, consider working with other CSOs and NGOs to demand it.

### **3.4.5 Preventing and reducing maternal and infant mortality**

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One of the best methods is to ensure that maternal health care services are available and accessible and that they are fairly distributed. Actions to monitor the provision of these services were given in Section 3.3.

#### **Lobbying the authorities**

CSOs could consider lobbying the authorities to:

- Propose and promote actions to enhance status of women and help them defend their rights (see the Main Book, Part II, Sections 3.3.1 and 11.1);
- Promote free and informed choice of timing and spacing of pregnancies;
- Allocate adequate financial and other resources to maternal health facilities;
- Introduce interventions that have been proved to work and are affordable;
- Make available sufficient contraceptives;
- Ensure that women and men are given all necessary information and services related to sexual and reproductive health in a non-judgmental way;
- Ensure that quick and correct referrals are made to other health facilities/professionals and if necessary, to safe abortion facilities;
- Allocate adequate financial and other resources to maternal health facilities; and
- Introduce interventions that have been proved to work and are affordable.

#### **Awareness-raising**

- Raise awareness of the risk factors;
- Increase understanding of the “three delays” (see Box 3); and
- Encourage family members – husbands, fathers-in-law, mothers-in-law – to register all cases of pregnancy with the health services and seek early check-ups. Persuade community leaders to facilitate this.

#### **Community-based interventions**

- Work with the community to consider what actions they can take towards preventing maternal mortality and to identify what the authorities could be asked to do; and
- Encourage local government to improve physical access to health care for women and their babies by improving transport and telephone networks.

Actions to reduce maternal mortality also help to reduce infant mortality, also known as “neo-natal” mortality. Some actions are listed below.

#### **Promoting registration of births and of maternal and child deaths**

Find out whether there is a system for recording maternal and child deaths. Also find out what efforts have been made to ensure that these are recorded (under-reporting may be a serious problem).

If there is no system, carry out a campaign to urge the government to provide one. In particular, point out that monitoring maternal and child deaths is essential in order to assess the scale of maternal and child mortality, its causes, and whether measures are being taken to address the problem.

#### **Raising awareness of the risks of infant mortality**

Point out that:

- Babies born less than 24 months after a previous birth have a significantly higher risk of dying; and
- The mother’s age is an important factor. The mortality rates of babies whose mothers are between 20 and 34 years old are lower than babies born to teenage mothers or older women.

#### **Projects to promote good breastfeeding**

Good breastfeeding practices help to prevent child mortality. Additional information on this can be found in the booklet on the right to food, Section 3.6, Box 26.

Promote awareness of good breastfeeding, particularly among older women, as they advise their daughters, but also among men.

### **3.5 Actions to address discrimination against people with mental illness**

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- Carry out a survey to find out what members of the community think about mental illness. Some people with mental illness may also be willing to talk about the way they are treated;
- Find out what mental health services are available locally and how many mental health professionals are employed; and
- With the help of a health professional, preferably with some training in mental health, analyse what you have discovered. Consider what may be done to improve the situation and make recommendations to the authorities.

**3.6**

**Actions to promote healthy workplace and natural environments**

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States must take steps to tackle the adverse effects of unhealthy environments in workplaces and the natural environment.

**3.6.1 Health surveys of workplace environments**

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A useful framework for action is to gather relevant information, carry out a survey, and lobby for changes.

- Gather relevant information:
  - Find out who in local government is responsible for health in general and, if relevant, workplace and environmental health;
  - Obtain copies of relevant regulations;
  - Find out what government regulations apply to working conditions; and
  - If there are trade unions in the area, suggest actions they could take, or propose to work together.
- Carry out a survey (see the Main Book, Part II, Section 6.5 and 6.6):
  - Select one or more workplaces, either a government one or a private company;
  - Ask if the workplace has safety regulations – companies should follow national legislation or guidelines and adapt these to the nature of the company’s business;
  - Assess whether these regulations are adequate;
  - Interview workers to ask about working conditions and note both negative and positive aspects;
  - Inquire about accidents or health problems resulting from working conditions;
  - Observe the workplace and note any signs of unclean or dangerous conditions; and
  - Ask what the company is doing to correct these.
- Lobby for changes:
  - Arrange a meeting with the company to discuss the findings of the survey, and explain that health protection in the workplace is a matter of human rights;
  - If necessary, take your concerns to the local health or government authorities who have obligations under the right to health to take action; and
  - Develop programmes to make companies and workers aware of the right to a healthy working environment.

**3.6.2 Mapping health hazards in the natural environment and taking action**

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An unhealthy natural environment affects health in urban and rural areas.

Pollution and other hazards, such as untreated sewage and unsafe roads can cause serious illnesses or injury. Erosion caused by deforestation may affect people’s health directly by destroying food production or indirectly by contributing to climate change (see Section 1.7).

- Map the area (see the Main Book, Part II, Section 4.2) and note situations that could affect people's health, such as untreated sewage or other waste, water pollution, the sale or preparation of food in unhealthy conditions, pollution from wood fires or vehicle exhaust fumes, unsafe buildings or roads;
- Investigate the causes and effects of these unhealthy environments and find out what the authorities are doing to improve the situation;
- Raise awareness about unhealthy environments and encourage people to take action, for example holding a "clean-up" campaign in the street or a school (self-help action), or writing a petition to the local authorities (pointing out their obligations); and
- Make reports, take photographs and discuss these with the appropriate authorities, including health authorities and government authorities.

#### Box 22: Example of an African NGO working on climate change

The Nigerian Environmental Study/Action Team (NEST) is an NGO working on the environment and sustainable development. NEST recognised that climate change can have negative effects on health and its underlying determinants: agriculture, land use, and water resources. NEST launched a scheme to adapt to climate change in five council areas in Abia State, Nigeria. The project aims to help reduce people's vulnerability to climate change.

For more information, visit: [www.nestinteractive.org](http://www.nestinteractive.org).

### 3.7

## Actions to increase prevention, treatment and control of diseases

### 3.7.1 Access to immunisation against diseases

Research in some countries has shown that more boys than girls have access to immunisation. The WHO says that all children should be immunised against > diphtheria, > tetanus, > pertussis, > measles, > poliomyelitis, tuberculosis and > hepatitis B. In countries affected by > yellow fever, children should also be immunised against that disease.<sup>39</sup>

CSOs could find out whether communities have access to immunisation by doing surveys and publishing the results. The surveys should gather data on the numbers of girls and boys under five years who have received immunisation and the diseases that were targeted. The data should show if there is a gender difference and if specific marginalised groups have been left out of the immunisation campaign.

**Box 23: Fathers take more responsibility for their children's health**

Many health programmes target mothers rather than both parents. However, research shows that when fathers understand child health and nutrition, the parents are more likely to prevent illness and seek treatment.

According to a study carried out in Ghana, when fathers were included in an immunisation campaign they started to take more responsibility for their children's health. This increased the numbers of children receiving immunisation.

Source: Brugha R. F., Kevani J. P., Swan V. *An investigation of the role of fathers in immunisation uptake*. International Journal of Epidemiology 1996; 25: 840.

**3.7.2 Monitoring access to health-related information and education**

Health-related information and health-related education are linked, but different. Health information provides the facts about health. People who have a health problem should be able to find relevant information. The health information service may provide information in leaflets, at a help desk or on a website. Health education is also about giving people the skills that help them to make sensible decisions about their health. Both are essential.

Access to information includes access to the resources that may be necessary to act on that information. For example:

- Information: mosquitoes breed in water and they transmit malaria;
- Education: to protect yourself from malaria it is necessary to eliminate their breeding grounds or use a mosquito net;
- Resources: chemicals to eliminate breeding grounds and mosquito nets treated with insecticide (chemicals that kill insects); and
- Monitoring: Monitoring access to health-related information and education could be done in three steps:
  - Interview members of different groups to find out what they know about specific aspects of health, including how to avoid or prevent illness. For example, ask women about the risks of maternal mortality; young people about HIV/AIDS and teenage pregnancies; or community leaders about environmental health;
  - Also ask if people know of any public information initiatives. If so, ask further questions: what did they think? Did it change their behaviour? Did they have access to resources that would enable them to act on the information?
  - Find out what the authorities have done to prevent the illnesses; whether they have used information programmes; whether these were in local languages; how they measured the programme's impact; and whether the resources to act on the information were available.

Write a report or do a radio interview to discuss the results of your findings. Highlight any good public campaigns. Draw attention to any gaps revealed by the report.

The authorities have a duty to educate the public about damaging myths and misinformation about certain diseases. CSOs can draw attention to failure to do so.

#### Box 24: An African coalition working on the right to health

The Africa Public Health Rights Alliance (APHRA) is a coalition that believes that if people are to enjoy their rights and contribute to Africa's development they need to be healthy. APHRA is an initiative of the Centre for Research, Education and Development of Rights in Africa (CREDO-Africa). Its main objective is to engage African institutions, member countries and the African public in promoting greater awareness and understanding of African health issues. APHRA's "15% Now!" campaign is based the pledge that AU member states made in Abuja in 2001 to allocate at least 15% of national budgets to health.

### 3.7.3 Monitoring access to medicines

The WHO provides a list of essential medicines. These are medicines "that satisfy the priority health care needs of a population". They are selected with regard to the number of people with the disease, safety, effectiveness, and cost. Unfortunately, many people cannot afford to buy medicine. The African Commission's Resolution 141 (2008) on Access to Health and Needed Medicines in Africa recognised that "access to needed medicines is a fundamental component of the right to health". It said that States parties to the African Charter have an obligation to provide them where appropriate, or facilitate access to them (Some extracts are given in Appendix 3).

With regard to access to medicines, CSOs could monitor the government obligations under Resolution 141:

- To ensure that essential medicines are available at the community level;
- To ensure that all people including marginalised individuals or communities have equal access to medicines;
- To allow the use of traditional medicines and healing practices that are scientifically sound and medically appropriate (see Boxes 8 and 9);
- To refrain from interfering with humanitarian aid that supplies necessary medicines; and
- To monitor the quality of medicines and ensure that available medicines are safe, effective and medically appropriate.

**3.8**

**Actions to increase the right to health of marginalised groups**

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To ensure non-discrimination and equality, a State must take measures in favour of disadvantaged communities and individuals.

**3.8.1 Monitoring access to health care by marginalised groups**

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Health facilities, goods and services must be accessible to all with special attention to vulnerable or marginalised groups including women, children, persons with disabilities and indigenous peoples. Accessibility also implies that medical services and underlying determinants of health, such as safe water and adequate sanitation facilities, are accessible, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Monitoring implementation of this commitment is essential to safeguard the health of marginalised groups and individuals. Gathering statistics is a job for professional statisticians. However, CSOs can gather useful information. Table 3 is a survey-tool that may be adapted to monitor access to health care by other vulnerable or marginalised groups. This table allows CSOs to identify suspected cases of lack of access to health care and to bring these to the attention of the appropriate authorities.

**Table 3: Monitoring access to health care by indigenous peoples**

**Objectives:**

Monitoring access to health care by indigenous peoples can:

- Help to identify the causes behind mortality and morbidity;
- Assess the government's response to address the situation; and
- Contribute towards constructing effective interventions.

**Tasks:**

1. **Before undertaking monitoring activities, obtain national statistics on life expectancy, birth and mortality rates and the main diseases.**
2. **Interview members of marginalised communities to obtain information on the topics listed below:**

**Relevant information:**

- Main causes of illness and death; .....
- .....
- .....
- Life expectancy; .....
- .....
- .....
- .....
- Differences in child mortality rates of indigenous peoples and other communities; .....
- .....
- .....
- Maternal mortality rates; .....
- .....
- .....
- .....
- Percentage of births attended by traditional birth attendants in indigenous areas; .....
- .....
- .....
- Whether health information is available in indigenous languages; and .....
- .....
- .....
- Prevalence of HIV/AIDS, TB and malaria in indigenous territories. ....
- .....
- .....

3. **Where appropriate, compare your information with the national statistics.**

**4. Find out about government efforts to remove barriers to accessing health care**

Find out if the government is working to:

Relevant information:

- Consult indigenous groups about health care provision; .....  
.....
- Take steps to identify and meet their specific health needs including the underlying determinants of health; .....  
.....
- Ensure the participation of indigenous peoples in decision making. CSOs could, for example, monitor how the authorities involve people in planning and evaluating health services (see the Main Book, Part II, Sections 6 and 7); .....  
.....
- Provide complaint and redress mechanisms to deal with right to health violations; and .....  
.....
- Promote indigenous knowledge and practices in relation to health. ....  
.....

**5. Analyse the information**

Does the health system discriminate against indigenous people regarding access to health care by:

Relevant information:

- Failing to address their specific health needs? .....  
.....
- Giving unjust advantages to groups that are already advantaged? .....  
.....

**6. Plan interventions**

Based on the information gathered and analysed above, NGOs and CBOs should, in consultation with the indigenous groups, plan and carry out awareness-raising campaigns.

## 3.9 Other actions to realise the right to health

This section adds to the actions in the previous sections. Before taking action, readers should refer to the Main Book Part II for advice on how to analyse problems and develop strategies for action.

Any action on the right to health should come through participatory activities with the community including workshops and participatory monitoring or research. For more information on involving the community, refer to the Main Book, Part II, Sections 5 and 6.

### 3.9.1 Right to health indicators

Indicators help to assess the steps taken by a State in meeting its obligations. They are a way of measuring the State's implementation of its obligations concerning the right to health.

Information about how to use indicators may be found in the Main Book, Part II, Section 7.3, Box 30.

There is no single set of indicators for the right to health. Each health goal requires a separate set of indicators. Most governments have indicators for measuring maternal mortality, child malnutrition, the number of deaths caused by malaria and many others. These indicators are likely to reflect outcomes, for example the percentage of women who have died in childbirth. They do not reflect human rights principles, such as whether these women died because they could not afford health care.

CSOs can develop their own human rights indicators that reflect the State's human rights obligations. This may be done by:

- Taking one of the elements of the right to health described in Section 1.4.2 (see column 1 in Table 4); and
- Deciding on one or more aspects of this element (column 2).

Once the indicators have been developed, disaggregated data should be gathered and placed in column 3.

After a certain period, the data should be updated: this will indicate whether or not the right is being progressively realised.

Table 4: Developing right to health indicators

Element of the right to health	Indicator	Qualitative information (comment) or quantitative information (number), examples of responses/actions
Availability of childbirth services	<ul style="list-style-type: none"> <li>Does the health policy call for increasing access to childbirth care?</li> <li>Is there a budget for this?</li> <li>How is it being spent?</li> </ul>	<p>Yes/no.</p> <p>Yes/no,</p> <p>Not fully spent/well spent</p>
Accessibility (physical accessibility) of emergency childbirth services within one hour	<ul style="list-style-type: none"> <li>Experience of women with or without access</li> </ul>	Gathered information from (number of) women to assess the different experiences of those who had timely access and those who did not.
Accessibility (economic)	<ul style="list-style-type: none"> <li>Are the services free? If not, what is the impact?</li> </ul>	20 women out of 38 interviewed said they had not used childbirth services because of the cost.
Acceptability	<ul style="list-style-type: none"> <li>Are the services welcoming and clean?</li> </ul>	2 facilities out of 6 were not clean.
Quality - access to a skilled birth attendant	<ul style="list-style-type: none"> <li>Number of villages with access to a skilled birth attendant?</li> </ul>	20 villages with access / 35 villages in the area.
Quality - access to clean water and safe sanitation	<ul style="list-style-type: none"> <li>Number of people / villages with or without access?</li> </ul>	22 villages with access, 13 without.
Access to a remedy	<ul style="list-style-type: none"> <li>Is there a way to make complaints?</li> <li>How many complaints resulted in a remedy?</li> </ul>	<p>Yes. But not satisfactory.</p> <p>2 out of 8 complaints made.</p>

Information obtained from using indicators should be analysed and presented in a short report.

Note: A small survey may not be very accurate. The report should admit this but call for a fuller investigation. The report should also contain recommendations for any immediate needs, for example the need for more skilled birth attendants. It could be sent to:

- Local or national authorities;
- Relevant national or international NGOs;
- The African Commission; or
- The Special Rapporteur on the right to health.

CSOs could also encourage the authorities to use human rights indicators to develop and implement their policies.

### **3.9.2 Right to health impact assessments**

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CSOs can play an important role in calling attention to the need for human rights impact assessments. These are described in Section 2.2. When any project is proposed, CSOs should try to obtain details from local authorities or the relevant government ministry or, in the case of projects supported by donors, from the relevant websites.

Projects should identify any potential impact. CSOs can make their own assessments by interviewing local officials as well as the people who may be affected by the project.

If the authorities agree to implement an impact assessment, CSOs should call for this to be based on human rights indicators. For example, in a project to build a new hospital, there should be indicators on accessibility by everyone in the area, particularly vulnerable groups. Services should meet indicators of acceptability and quality. Additionally there should be indicators for seeking input from the local community.

### **3.9.3 Analysing policies and budgets**

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A simple three-step process for monitoring and analysing budgets is described in the Main Book, Part II, Section 7.3. For more advanced work, look at the resources published by the International Human Rights Internship Program (IHRIP), and the International Budget Partnership, or the booklet on budget monitoring in the Haki Zetu series (publication forthcoming).

### **3.9.4 Building alliances, mobilising communities and lobbying the government**

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This topic is covered in the Main Book, Part II, Sections 4 and 9.

Working with others to advance the right to health could include:

- Working with community health workers to encourage them to use the human rights-based approach in their work; or
- Bringing together people with similar health concerns to discuss the problems and identify ways to help each other or to bring the matter to the authorities' attention.

Allies could include other NGOs or CBOs working on the right to health, religious groups, environmental groups and professionals including doctors, nurses, and health workers.

### **3.9.5 Reporting to the CESCR and the African Commission**

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Organisations interested in providing information to these bodies should refer to the Main Book, Part I, Section 3.5 and Part II, Section 10.

Those interested in submitting information to the CESCR should refer to the guidelines for reporting to the CESCR ([www.unhcr.ch/tbs/doc/nsf/t](http://www.unhcr.ch/tbs/doc/nsf/t)).

The African Commission uses a similar process. Visit its website at:  
[www.achpr.org/english/\\_info/state\\_procedureen.html](http://www.achpr.org/english/_info/state_procedureen.html).

See the Main  
Book, Part 2,  
Section 10

### **3.9.6 The international and regional arena**

It is difficult for local groups to participate in regional or international campaigns, but it is important to know about them, particularly in countries where the government or national NGOs are participating in these arenas. Addresses and websites are included in Appendix 2.

#### **The Millennium Development Goals (MDGs)**

The MDGs 4, 5, and 6 relate specifically to health care but all the MDGs are relevant. See Appendix 4.

#### **The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)**

The campaign, launched in May 2009, includes goals to reduce maternal and infant mortality and to accelerate the availability and use of universally accessible health services of good quality.

At the 15th AU Summit in August 2010, African leaders again urged countries to spend “at least 15% of their national budgets, excluding donor contributions, on health” (see Box 24), and called for countries to produce annual reports on maternal and child health to share at future AU meetings. (Google “CARMMA” for national participation).

#### **World health days**

At the time of writing there is no Africa Health Day, but some NGOs are calling for one to be adopted. Please check the following dates before taking action as some may change:

- World health day – 7 April;
- World AIDS day – 1 December; and
- World mental health day – 10 October.

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
ARV/ART	Anti-RetroViral drugs/Treatment
AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention/Committee on the Elimination of All Forms of Discrimination Against Women
CESCR (UN)	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organisation
FGC/FGM	Female genital cutting/mutilation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICPMW	International Convention on the Protection of the Rights of All Migrant Workers and members of their families
IGO	Intergovernmental organisation
IPPF	International Planned Parenthood Federation
HRBA	Human rights-based approach to development
MDGs	Millennium Development Goals
NGO	Non-governmental organisation
STIs/STDs	Sexually transmitted infections/diseases
TB	Tuberculosis
WHO	World Health Organisation
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	UN Population Fund
UDHR	Universal Declaration of Human Rights
UNICEF	UN Children's Fund

Terms in *italics* represent entries found elsewhere in the Glossary.

## A

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### **Abortion**

Termination of pregnancy before the *foetus* can survive outside the womb. An abortion can be spontaneous, when it is called a "miscarriage", or it can be brought about by deliberate intervention, when it is called "induced abortion". It is with this last meaning that the word is generally used.

### **Albinism**

An inherited condition caused by a lack of melanin (pigment), which protects the skin from ultraviolet light. Affected people have pale skin, hair and eyes and are vulnerable to eye problems and skin cancer. They often suffer discrimination and ill treatment.

### **Anaemia / anaemic**

People who have less than the normal number of red blood cells in the blood "have anaemia" or "are anaemic". Red blood cells carry oxygen. Anaemia makes people feel tired and shaky.

### **Anaesthetist**

A specialist who gives a patient specific drugs (an anaesthetic) so that she or he does not feel pain during an operation.

### **Antiretroviral therapy (ART)**

Treatment with medicines (antiretroviral drugs, ARVs) that suppresses or stops a retrovirus, such as the retrovirus that causes AIDS.

## B

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### **Burden of disease**

The impact of a health problem in an area or country. It is measured by financial cost, death, incidence of disease, or other indicators.

### **Bacteria**

Micro-organisms (very small living things of one or more cells) present in almost every environment, including in the human body. Some types of bacteria cause diseases and others cause things to decay.

C

**Chlamydia**

An *STI (sexually transmitted infection)* caused by a bacteria in or on the sexual organs of men and women. People may feel pain while urinating (peeing), itching and having secretion/discharge. It can cause inflammations and ultimately even infertility. Many people do not know they have chlamydia. Chlamydia can easily be treated, for both sexual partners.

**Cholera**

An acute *infectious disease* that causes *diarrhoea* and vomiting. It is mostly found in areas where water and sanitation are unsafe.

**Condom**

A tube closed at one end made of thin rubber or plastic that is placed over an erect penis before sexual intercourse. It collects semen to prevent pregnancy. It also prevents *STIs*. Less used, but also effective are female condoms, which are thin pouches placed in the vagina.

**Contraception / Contraceptives**

Birth control methods, measures or devices, for example by (using) *condoms* or contraceptive pills.

D

**Demographic**

Demography is the study of human populations. Demographic surveys find out how the population of a country or area is composed and develops according to specific classifications (size, density, distribution, births and deaths, etc.).

**Diabetes**

A disease that causes thirst, frequency of urination, tiredness and many other symptoms.

**Diagnose / Diagnosis**

The process of finding out the nature and cause of a disease or injury, including through examination of the patient and laboratory tests.

**Diarrhoeal disease (diarrhoea)**

A container name for diseases that lead to liquid stools. It includes *cholera*, *typhoid* and bacillary dysentery, which are spread through food or water contaminated by human waste. Victims become dehydrated (lack of water).

**Disaggregated information**

Information or data that is separated into component parts, for example separate figures for women and men, for different regions or districts, for different religious, ethnic or social groups.

**Diphtheria**

A disease spread by coughing and sneezing. If untreated it can cause heart problems.

**Drugs**

Chemical compounds used to diagnose, prevent or treat diseases or other health conditions. Also see *pharmaceuticals*.

**E**

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**Eclampsia**

High blood pressure in a pregnant woman leading to a coma (deep unconsciousness) or convulsions (fits) shortly before or after the birth.

**Environmental hygiene / environmental sanitation**

Activities aimed at improving environmental conditions that affect people's health, such as efficient and safe waste disposal.

**Epidemic**

A widespread outbreak of an *infectious disease*.

**Epidemiology**

The branch of medicine (health science) that deals with the study of the causes, distribution, and control of disease in populations.

**Equity**

Something that is fair or impartial.

**Essential primary health care**

This includes health information, the underlying determinants, 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.

**F**

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**Faeces**

Solid waste which collects in the human digestive system and is expelled from the body through the anus.

**Family planning**

The planning of when to have children, and the use of birth control and other techniques including sexuality education. The WHO also speaks of "fertility regulation".

### **FGC/FGM**

Female genital cutting or circumcision (FGC), also known as female genital mutilation (FGM). This is any procedure involving the partial or total removal of the external female genital organs or injury to these. FGC is usually carried out for cultural reasons.

### **Fistula**

Fistulae are holes that are created between the vaginal wall and the bladder (vesicovaginal fistula VVF), and holes created between the vaginal wall and the rectum (rectovaginal fistula RVF). Fistulae are usually caused by obstructed labour during childbirth, or by *FGC/FGM*.

### **Foetus (also spelt Fetus)**

Unborn baby or embryo (baby in the womb in the early stage of development).



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### **Gender**

This term refers not simply to women or men but to the relationship between them. Gender equality is when the different behaviour, aspirations, needs and rights of women and men are valued equally. Gender *equity* means fairness of treatment for women and men, according to their respective needs. This may include equal treatment (for example access to immunisation) or treatment that is different but considered equivalent in terms of rights, and opportunities (such as the right to antenatal care).

### **Genetic disorder**

An inherited disease caused by a defective gene or chromosome. A chromosome carries characteristics from parent to child. A gene is part of a chromosome.

### **Gonorrhoea**

An *STI (sexually transmitted infection)* caused by a bacteria in or on the sexual organs of men and women. The usual symptoms in men are burning with urination and penile discharge. Women may have slight vaginal discharge and pelvic pain. Gonorrhoea can cause inflammations in the abdomen and ultimately even infertility. Gonorrhoea can easily be treated, for both sexual partners.



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### **Haemorrhage**

Severe bleeding from ruptured blood vessels.

### **Health workers**

All those involved in health care both in the private and public health sectors. They include traditional healers whether or not these have been incorporated into the health system.

### **Hepatitis**

A disease that is usually caused by a *virus*. Hepatitis B is caused in the same way as HIV/AIDS.

## I

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### **Immunisation**

Also called *vaccination*. It is the delivery of a vaccine, usually through an injection, which carries a very small dose of a disease. This stimulates the immune system, the natural disease-fighting system of the body, which can recognise the disease and produce substances to destroy or disable the organisms that cause it.

### **Impact assessment (or social impact assessment)**

A study to identify the possible negative and positive effects of a policy, programme or project, for example a project to build a chemical factory near a river. The assessment should consider possible effects on health, the environment and other issues (also see Section 2.2).

### **Infectious disease**

A disease caused by a micro-organism entering the body, such as *malaria* which is transmitted by mosquitoes or HIV/AIDS which is transmitted by one person to another.

### **Infertility**

Persistent failure to conceive a child after regular unprotected sexual intercourse caused by physical problems in a man's or woman's reproductive system. About one third of fertility problems occur solely in women, one third in men and the remaining third could occur in either sex.

### **Infirmity**

A bodily ailment or weakness, for example one brought on by old age or undernutrition.

### **Influenza**

A respiratory (breathing) disease that attacks the cells in the upper respiratory tract ("wind pipe"). It is also known as "flu". It is highly *infectious*.

### **Informed consent**

If someone has complete information and agrees for example to be treated or examined.

### **Injection**

Insertion of liquid (usually medicine) into the body with a syringe.

### **Intervention**

Action taken to prevent, improve or stabilise a health condition, to promote good health behaviour or to prevent bad health behaviour.

L

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**Leprosy**

An *infectious disease*. If untreated it can cause permanent damage to the skin, nerves, limbs and eyes.

**Licensing body**

A body, usually a government agency, that provides licenses to others to carry out activities or provide services. For example medical professionals require a license to carry out professional activities.

M

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**Malaria**

An infectious disease caused by bites of infected mosquitoes that inject the malaria parasite into red blood cells, making them rupture. Its symptoms include fever and headache, in severe cases progressing to coma or death.

**Measles**

A highly *infectious disease* caused by a *virus* and spread through coughing and sneezing. Infected people develop a rash on face and body.

**Meningitis**

An inflammation of the protective membranes covering the brain and spinal cord. This is a deadly disease that is particularly prevalent in an area stretching from Senegal to Ethiopia.

**Menopause**

A time in a woman's life when menstruation (the monthly flow of blood) ceases and she becomes infertile (*infertility*).

**Midwife / midwifery**

A midwife is a person who is trained to assist women in childbirth. Midwifery is the skill or act of assisting in childbirth.

**Morbidity**

The rate of disease or proportion of diseased persons in a given locality.

N

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**Non-communicable disease**

Disease that cannot be "caught" from another person, and cannot be "passed on" to other persons.

O

**Obstetric**

To do with childbirth.

P

**Parasite**

A living creature (a small animal or plant) that lives in a close relationship with another organism, its host, and causes it harm.

**Pertussis, or whooping cough**

This is a highly *infectious disease* spread by coughing and sneezing.

**Pharmaceutical/Pharmacy**

Pharmacy is the branch of health science that is concerned with the preparing and handing out *drugs* and advising people on how to use them properly. A pharmacy is a place that stores and gives out (or sells) these drugs, which are also called pharmaceuticals.

**Placenta**

A membrane or thin skin that lines the womb and supplies nourishment to the unborn baby.

**Poliomyelitis (polio)**

A highly *infectious disease* caused by a *virus* which can lead to paralysis (loss of ability to move) or death.

**Pollutants**

Harmful substances that contaminate the soil, water, or atmosphere and cause pollution.

**Post exposure contraception**

*Contraception* after sexual intercourse, for example by taking the "morning after pill".

**Post-traumatic stress disorder (PTSD)**

A mental illness caused by experiencing or seeing a traumatic event, such as war, a hurricane, rape, physical abuse or a bad accident. PTSD makes you feel stressed and afraid after the danger is over, with symptoms like flashbacks, sleeping problems, angry outbursts, feeling alone, worried, guilty or sad. It affects your life and the people around you.

**Practitioner**

A medical practitioner is someone who is licensed to practise medicine. Some practitioners carry out harmful traditional practices.

**Pre-natal**

Pre-natal means before (giving) birth.

**Preventive measures**

Steps taken to prevent illness or injuries, rather than curing them or treating their symptoms. They include the early detection of a disease, preventing its transmission and reducing negative impacts of already established disease. Public information campaigns are central to preventive measures.

**Psychological or physical rehabilitation**

Treatment aimed at improving a physical or psychological condition or function that has been lost or weakened by disease or traumatic injury (*trauma*).

**Psychosis**

Fundamental derangement of the mind, which makes people lose contact with reality as evidenced by delusions, hallucinations, and disorganised speech and behaviour.

R

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**Reproductive health**

A state of complete physical, mental and social well-being in all matters related to the reproductive system and to its functions and processes (to reproduce human beings/ children), for example in matters related to sexuality, pregnancy and childbirth.

**River blindness**

A disease caused by a parasite transmitted by the bites of blackflies that live in fast moving streams. Inside the body, the worms form bumps in the skin where they mate and produce larvae that can cause itching and blindness.

S

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**Sepsis**

Infection.

**Sexual identity**

A person's feelings about her or his sexuality and how she or he expresses these feelings, whether heterosexual, homosexual, bisexual, or otherwise.

**Sexual orientation**

The direction of a person's sexual interest toward members of the same sex, the opposite sex or both sexes.

**Sexually transmitted infection (STI) / disease (STD)**

An infection or disease contracted by sexual contact, especially by sexual intercourse, oral and anal sex. Well-known STIs/STDs are *chlamydia*, *gonorrhoea*, and HIV/AIDS.

**Sleeping sickness**

An *infectious disease* of humans and animals transmitted by the tsetse fly. It causes fever and severe headache and can be fatal.

**Sterilisation**

This word has two meanings:

1. Destroying bacteria or other organisms that might cause infection;
2. A permanent method of *contraception*, to make sure people cannot get (any more) children. Such sterilisation involves operating on the male or female organs to stop the egg and sperm meeting.

**Stigma**

The shame attached to something that is regarded as disgusting or unacceptable.

**T****Taboo**

Something is taboo if it is considered culturally or morally inappropriate.

**Tetanus (“Lock-jaw”)**

A disease caused when bacteria that live in the soil enter the body through a wound or insect bite. In severe cases the muscles used to breathe can tighten (or spasm), causing a lack of oxygen to the brain and other organs.

**Therapy**

Any form of treatment of illness or disorder.

**Trachoma**

A chronic (long-lasting or recurring) inflammation of the eye. Trachoma is contagious – it can be passed on to others through touch.

**Trauma/traumatic**

A serious injury or shock to the body, as a result of violence or an accident. It can also be an emotional shock or wound.

**Transgender**

When a person's gender does not conform to conventional notions of male or female gender roles (definitions vary).

### **Transmission**

Passing on.

### **Tuberculosis**

A disease that mostly affects the lungs but can affect the central nervous system (also see *meningitis*) or other organs. It can be diagnosed by a skin test. A positive test should be followed by a chest X-ray to determine whether the infection is active or dormant (sleeping). Those who have immune system problems such as HIV/AIDS catch tuberculosis more easily than those with strong immune systems.

### **Typhoid**

An *infectious disease* caused by *Salmonella* bacteria that is deposited in food or water by a human carrier.



### **Vaccine**

See *immunisation*.

### **Virus**

A tiny *infectious* agent that needs a “host”, like a human cell to live in. Viruses can cause various illnesses including colds and HIV/AIDS.



### **Yellow fever**

A viral infection transmitted by mosquitoes in tropical countries. It can lead to kidney failure and *meningitis*, a disease that affects the circulation of the blood.

- 1 Declaration of Alma-Ata, 1978, and constitution of the WHO.
- 2 *Malaria effort a rare public-health success story in Africa*, Stephanie Nolen, Kenya Globe and Mail, 31 October 2008.
- 3 WHO third regional consultation in Human Resources for Health in Pretoria (11 October 2011). Available online: [www.sabc.co.za/news/a/c178d20048a6893382d-fee1073e9045d/Africa-urged-to-improve-health-system-20111011](http://www.sabc.co.za/news/a/c178d20048a6893382d-fee1073e9045d/Africa-urged-to-improve-health-system-20111011).
- 4 *Sub-Saharan Africa's Mothers, Newborns, and Children: Where and Why Do They Die?* Mary V. Kinney et. al, PLoS Medicine, June 2010. Available online: [www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000294](http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000294).
- 5 AU Africa Health Strategy, 2007-2015, paragraph 9 (Online available: see Appendix 1).
- 6 BBC: *Is Africa beating HIV/AIDS?* Available online: [www.bbc.co.uk/blogs](http://www.bbc.co.uk/blogs).
- 7 *Everybody's business: Strengthening health systems to improve health outcomes*, WHO's framework for action (2007). Available online: [www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf).
- 8 Paul Hunt and Gunilla Backman, *Health systems and the right to the highest attainable standard of health* (2008). Available online: <http://hhrjournal.org/index.php/hhr/article/viewArticle/22/69>.
- 9 WHO figure, see for example WHO's *10 Facts on Maternal Health* at: [www.who.int/features/factfiles/maternal\\_health/maternal\\_health\\_facts/en/index4.html](http://www.who.int/features/factfiles/maternal_health/maternal_health_facts/en/index4.html).
- 10 For some examples, see Human Rights Watch reports on South Africa: "*Stop Making Excuses*" (August 2011) and "*No Healing Here*" (December 2009). [www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care](http://www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care) and [www.hrw.org/publications/reports?topic=All&region=122](http://www.hrw.org/publications/reports?topic=All&region=122).
- 11 Guttmacher Institute, "*Facts on Investing in Family Planning and Maternal and Newborn Health*" (2010), available online at: [www.guttmacher.org/pubs/FB-AIU-Africa.pdf](http://www.guttmacher.org/pubs/FB-AIU-Africa.pdf).
- 12 See previous note.
- 13 Sources: Ipas website, [www.ipas.org](http://www.ipas.org); recent WHO data analysed in Sedgh/Singh/Shah/Ahman/Henshaw/Bankole, *Induced abortion: incidence and trends worldwide from 1995 to 2008*, in *The Lancet*, January 2012.
- 14 AU Africa Health Strategy 2007-2015, paragraph 96.
- 15 WHO Fact Sheet No. 348, November 2010. Available online: [www.who.int/mediacentre/factsheets/fs348/en/index.html](http://www.who.int/mediacentre/factsheets/fs348/en/index.html).
- 16 See previous reference; see also "*Most maternal deaths in Sub-Saharan Africa could be avoided*", available online at [www.empowernewsmag.com/listings.php?article=1203](http://www.empowernewsmag.com/listings.php?article=1203).
- 17 WHO Fact Sheet No. 241, February 2012, Available online: [www.who.int/mediacentre/factsheets/fs241/en/](http://www.who.int/mediacentre/factsheets/fs241/en/).
- 18 See Ahmed Okasha (2002), "*Mental Health in Africa; the role of the WPA*", in *World Psychiatry*, 2002 February; 1(1): 32–35; available online at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC1489826/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489826/).
- 19 See WHO Mental Health Atlas 2011, graph 2.1.3 on page 27; available online at [www.who.int/mental\\_health/publications/mental\\_health\\_atlas\\_2011/en/index.html](http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/index.html).
- 20 See note 18.

- 21 Also see note 18. More details on the limited mental health care plans and facilities in Africa: WHO Mental Health Atlas 2011, see note 19.
- 22 See [www.who.int/mediacentre/news/releases/2006/pr32/en/index.html](http://www.who.int/mediacentre/news/releases/2006/pr32/en/index.html)  
More information can be found in the WHO study “Preventing disease through healthy environments - towards an estimate of the environmental burden of disease” (2006).
- 23 WHO Fact Sheet No. 330, August 2009.
- 24 ACHPR Resolution 141 (2008) on essential medicines. Available online: [www.achpr.org/english/resolutions/resolution141\\_en.htm](http://www.achpr.org/english/resolutions/resolution141_en.htm).
- 25 CESCRC General Comment No. 14, Paragraph 12 (a) and WHO Model Lists of Essential Medicines ([www.who.int/medicines/publications/essentialmedicines/](http://www.who.int/medicines/publications/essentialmedicines/)).
- 26 Text available on: [www.unep.org/health-env/pdfs/libreville-declaration-eng.pdf](http://www.unep.org/health-env/pdfs/libreville-declaration-eng.pdf).
- 27 Officially, a person is said to have AIDS if she/he has one or more of a list of more than 20 officially defined opportunistic infections or related cancers.
- 28 WHO Progress report 2011: Global HIV/AIDS response, see also [www.who.int/hiv/pub/progress\\_report2011/regional\\_facts/en/index.html](http://www.who.int/hiv/pub/progress_report2011/regional_facts/en/index.html).
- 29 See [www.who.int/gho/hiv/epidemic\\_status/cases\\_all/en/index.html](http://www.who.int/gho/hiv/epidemic_status/cases_all/en/index.html).
- 30 WHO Progress report 2011: Global HIV/AIDS response, see also [www.who.int/hiv/pub/progress\\_report2011/global\\_facts/en/index1.html](http://www.who.int/hiv/pub/progress_report2011/global_facts/en/index1.html).
- 31 See previous reference; for the Summary report, see: [www.who.int/hiv/pub/progress\\_report2011/summary\\_en.pdf](http://www.who.int/hiv/pub/progress_report2011/summary_en.pdf).
- 32 Amnesty International, [www.amnesty.org](http://www.amnesty.org), and [www.aidslex.org/site\\_documents/CR-0104E.pdf](http://www.aidslex.org/site_documents/CR-0104E.pdf).
- 33 Afrol News 4 December 2010. Available online: [www.afrol.com/articles/3064131](http://www.afrol.com/articles/3064131).
- 34 *South Africa: Sexual violence affects 10 percent of men, study shows*. Mariya Karimjee Global Post, October 19, 2011 Available online: [mobile.globalpost.com/dispatch/news/regions/africa/south-africa/111019/south-africa-sexual-violence-men](http://mobile.globalpost.com/dispatch/news/regions/africa/south-africa/111019/south-africa-sexual-violence-men).  
Martin Shenkler, *The Violence Against Men That No One Wants to Talk About*, Second Chance Africa, 2011 Available online: <http://secondchanceafrica.org/articles/the-violence-against-men-that-no-one-wants-to-talk-about>.
- 35 Krug et al., 2002; Mugawe & Powell, 2006.
- 36 The questionnaire used for a Demographic and Health Survey in South Africa can be found at [measuredhs.com/pubs/pdf/FR131/22Ap](http://measuredhs.com/pubs/pdf/FR131/22Ap).
- 37 Population Council [www.popcouncil.org/projects/301\\_TradLeadSGBVSouthAf.asp](http://www.popcouncil.org/projects/301_TradLeadSGBVSouthAf.asp)
- 38 [www.unicef.org/infobycountry/mali\\_52714.html](http://www.unicef.org/infobycountry/mali_52714.html).
- 39 [www.un.org/esa/sustdev/natlinfo/indicators/methodology\\_sheets/health/immunization.pdf](http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/health/immunization.pdf).

Appendix 1: International and regional human rights laws and standards

Appendix 2: Sources and resources on the right to health

Appendix 3: NGOs and IGOs

Appendix 4: The Millennium Development Goals and their progress in Africa

Appendix 5: Template for making your own checklist



## Appendix 1. International and regional human rights laws and standards

This tool consists of quotations on the right to health from international and regional human rights standards that may be used in reports or recommendations to governments. Quoting the national law and regional or international standards shows that human rights workers are aware of State obligations and increases the impact of their work.

For further information about using regional and international standards see the Main Book, Part I, Section 3.3. For international and regional human rights and standards on rights related to the right to health, including the rights to adequate housing, food, safe water and sanitation, please refer to the relevant booklet in this series.

### **How to use the table:**

Look for the topic of interest in column 1. Column 2 contains relevant articles. It is best to look at the complete texts whenever possible: websites are given for this purpose.

The quotations were selected from the following human rights treaties and standards:

- Human rights treaties
  - African Charter on Human and Peoples' Rights:  
[www.achpr.org/english/\\_info/charter\\_en.html](http://www.achpr.org/english/_info/charter_en.html)
  - African Charter on Human and Peoples' Rights – Women's Protocol:  
[www.achpr.org/english/\\_info/women\\_en.html](http://www.achpr.org/english/_info/women_en.html)
  - African Charter on the Rights and Welfare of the Child:  
[www.africa-union.org/root/ua/conferences/mai/hrst/charter%20english.pdf](http://www.africa-union.org/root/ua/conferences/mai/hrst/charter%20english.pdf)
  - African Youth Charter: [www.africa-union.org/child/home.htm](http://www.africa-union.org/child/home.htm)
  - International Covenant on Economic, Social and Cultural Rights:  
<http://www2.ohchr.org/english/law/ccpr.htm>
  - Convention on the Elimination of All Forms of Discrimination against Women:  
<http://www2.ohchr.org/english/law/cedaw.htm>
  - Convention on the Rights of the Child: <http://www2.ohchr.org/english/law/crc.htm>
  - Convention on the Rights of Persons with Disabilities:  
[www.un.org/disabilities/convention/conventionfull.shtml](http://www.un.org/disabilities/convention/conventionfull.shtml)
  - International Convention Related to the Status of Refugees:  
<http://www1.umn.edu/humanrts/instree/v1crs.htm>
  - International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: <http://www1.umn.edu/humanrts/instree/n8icpmw.htm>

- Human rights standards, advice and interpretations
  - Universal Declaration of Human Rights: [www.unhcr.ch/udhr/lang/pcm.htm](http://www.unhcr.ch/udhr/lang/pcm.htm)
  - General Comments of the Human Rights Committee and the Committee on Economic, Social and Cultural Rights: <http://www2.ohchr.org/english/bodies/cescr/comments.htm>
  - United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care: [www.un.org/documents/ga/res/46/a46r119.htm](http://www.un.org/documents/ga/res/46/a46r119.htm)
- Decisions of international programmes
  - The Declaration of Alma-Ata: The Principles of Primary Health Care
  - Millennium Development Goals: [www.un.org/millenniumgoals/goals.html](http://www.un.org/millenniumgoals/goals.html)
- Regional programmes
  - The AU Africa Health Strategy: 2007 – 2015, [www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA\\_HEALTH\\_STRATEGY.pdf](http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf)
  - The Southern African Development Community (SADC) Protocol on Health (Entered into force on 14 August 2004): [www.sadc.int/index/browse/page/152](http://www.sadc.int/index/browse/page/152)
  - The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA): <http://africa.unfpa.org/public/lang/en/pid/7130>

Table 5: The right to health

<p><b>Right to health</b></p>	<p><b>UDHR, Article 25</b></p> <p>(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.</p> <p>(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.</p> <p><b>ACHPR, Article 16</b></p> <p>1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.</p> <p>2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.</p> <p><b>ICESCR, Article 12</b></p> <p>1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.</p> <p>2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:</p> <p>(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;</p> <p>(b) The improvement of all aspects of environmental and industrial hygiene;</p> <p>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;</p> <p>(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.</p>
<p><b>Right to health of women</b></p>	<p><b>CEDAW, Article 12</b></p> <p>1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.</p> <p>2. [...] States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.</p> <p style="text-align: right;"><i>&gt; continued</i></p>

<p><b>Right to health of women</b></p>	<p><b>ACHPR – Women’s Protocol, Article 14</b> Health and reproductive rights</p> <ol style="list-style-type: none"> <li>1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:             <ol style="list-style-type: none"> <li>a) the right to control their fertility;</li> <li>b) the right to decide whether to have children, the number of children and the spacing of children;</li> <li>c) the right to choose any method of contraception;</li> <li>d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;</li> <li>e) the right to be informed on one’s health status and on the health status of one’s partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;</li> <li>f) the right to have family planning education.</li> </ol> </li> <li>2. States Parties shall take all appropriate measures to:             <ol style="list-style-type: none"> <li>a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;</li> <li>b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;</li> <li>c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.</li> </ol> </li> </ol> <p>2.2 States Parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.</p>
	<p><b>MDG 5: Improve Maternal Health</b></p> <p>Target 1: Reduce by three-quarters the maternal mortality ratio</p> <p>Target 2: Achieve universal access to reproductive health</p>
<p><b>Right to health of children and youth</b></p>	<p><b>CRC, Article 24</b></p> <ol style="list-style-type: none"> <li>1. States Parties recognise 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.</li> </ol> <p style="text-align: right;"><i>&gt; continued</i></p>

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 [...] 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.

#### **ANCW, Article 1.3**

Any custom, tradition, cultural or religious practice that is consistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged.

#### **ACRWC, Article 14: Health and Health Services**

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties [...] shall undertake to pursue the full implementation of this right and in particular shall take measures:
  - (a) to reduce infant and child mortality rate;
  - (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 ensure the provision of adequate nutrition and safe drinking water;
  - (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
  - (e) to ensure appropriate health care for expectant and nursing mothers;
  - (f) to develop preventive health care and family life education and provision of service;
  - (g) to integrate basic health service programmes in national development plans;
  - (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;

> *continued*

	<ul style="list-style-type: none"> <li>(i) to ensure the meaningful participation of non-governmental organisations, local communities and the beneficiary population in the planning and management of a basic service programme for children;</li> <li>(j) to support through technical and financial means, the mobilisation of local community resources in the development of primary health care for children.</li> </ul> <p>3. Any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged.</p> <hr/> <p><b>MDG 4: Reduce child mortality</b> Target 1: Reduce by two thirds between 1990-2015, the under five mortality rate</p> <hr/> <p><b>African Youth Charter, Article 16</b></p> <ul style="list-style-type: none"> <li>1. Every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health.</li> <li>2. States Parties shall [...] take measures to:             <ul style="list-style-type: none"> <li>a) Make available equitable and ready access to medical assistance and health care especially in rural and poor urban areas with an emphasis on the development of primary health care;</li> <li>b) Secure the full involvement of youth in identifying their reproductive and health needs and designing programmes that respond to these needs with special attention to vulnerable and disadvantaged youth;</li> <li>c) Provide access to youth friendly reproductive health services including contraceptives, antenatal and post natal services;</li> <li>d) Institute programmes to address health pandemics in Africa such as HIV/AIDS, tuberculosis and malaria; [...]</li> </ul> </li> </ul> <p>The Charter has other provisions concerning youth living with HIV/AIDS and the abuse of alcohol, tobacco and drugs and to address the problem of early marriage.</p>
<p><b>Right to health of persons with disabilities</b></p>	<p><b>CRPD, Article 25</b></p> <p>States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:</p> <ul style="list-style-type: none"> <li>a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;</li> </ul> <p style="text-align: right;"><i>&gt; continued</i></p>

	<ul style="list-style-type: none"> <li>b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;</li> <li>c) Provide these health services as close as possible to people's own communities, including in rural areas;</li> <li>d) Require health professionals to provide care of the same quality to persons with disabilities as to others [...]</li> <li>e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;</li> <li>f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.</li> </ul>
<p><b>Right to health of migrants</b></p>	<p><b>ICRMWC, Article 28</b>  Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment. Also see CERD, General Recommendation No. 30 and CESCR, General Comment No. 14.</p>
<p><b>Access to needed medicines</b></p>	<p><b>Resolution on Access to Health and needed Medicines in Africa (ACHPR/Res.141 (XXXVIII) 08)</b>  The African Commission [...] URGES States to guarantee the full scope of access to needed medicines, including:</p> <ul style="list-style-type: none"> <li>• The <i>availability</i> in sufficient quantities of needed medicines, including existing medicines and the development of new medicines needed for the highest attainable level of health;</li> <li>• The <i>accessibility</i> of needed medicines to everyone without discrimination, Including: <ul style="list-style-type: none"> <li>- Physical accessibility of needed medicines to all;</li> <li>- Economic accessibility (affordability) of needed medicines to all;</li> <li>- Information accessibility about the availability and efficacy of medicines;</li> </ul> </li> <li>• The <i>acceptability</i> of medicine supplies, being respectful of cultural norms and medical ethics;</li> <li>• The <i>quality</i> of medicine supplies, ensuring that available medicines are safe, effective and medically appropriate; [...]</li> </ul> <p style="text-align: right;">&gt; <i>continued</i></p>

<p><b>UN Principles for the Protection of Persons with Mental Illness</b></p>	<ol style="list-style-type: none"> <li>1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.</li> <li>2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.</li> <li>3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.</li> <li>4. There shall be no discrimination on the grounds of mental illness [...]. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory [...].</li> </ol>
<p><b>Accountability and remedies</b></p>	<p><b>CESCR General Comment No. 14,</b></p> <p><b>Para. 59</b> Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsman offices, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.</p> <p><b>Para. 60</b> The incorporation in the domestic legal order of international instruments recognising the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to adjudicate violations of the right to health, or its core obligations, by direct reference to the Covenant.</p> <p><b>Para. 62</b> States Parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalised groups in the realisation of their right to health.</p>
<p><b>International assistance and cooperation</b></p>	<p><b>ICESCR Article 2 (1)</b> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.</p>

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**Core obligations**

**General Comment No. 14, Para. 43**

[...] the core obligations arising from Article 12 [of the ICESCR] include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
  - (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
  - (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe water;
  - (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
  - (e) To ensure equitable distribution of all health facilities, goods and services;
  - (f) To adopt and implement a national public health strategy and plan of action.
- [...]

**Para. 44 [additional core obligations]**

- (a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) To provide immunisation against the major infectious diseases occurring in the community;
- (c) To take measures to prevent, treat and control epidemic and endemic diseases;
- (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- (e) To provide appropriate training for health personnel, including education on health and human rights.

**Table 2: International Programmes on the right to health**

<p><b>The Declaration of Alma-Ata</b></p>	<p>Principles of Primary Health Care:</p> <ul style="list-style-type: none"> <li>• Equity (even distribution according to need);</li> <li>• Community participation;</li> <li>• Involving all relevant government departments and other actors (the “multi-sectoral” approach);</li> <li>• Effective planning;</li> <li>• Integrated referral systems (systems to refer patients to other parts of the health system for appropriate attention);</li> <li>• Promoting knowledge about health and healthy living;</li> <li>• Suitably trained doctors, nurses and other staff; and</li> <li>• International cooperation.</li> </ul> <p>Health interventions:</p> <ul style="list-style-type: none"> <li>• Health education;</li> <li>• Improved food supply and proper nutrition;</li> <li>• Adequate supply of safe water and sanitation;</li> <li>• Maternal and child health care, including family planning;</li> <li>• Immunisation against major infectious diseases;</li> <li>• Appropriate treatment for common diseases and injuries; and</li> <li>• Provision of essential drugs.</li> </ul> <p>In addition, governments, including those with very limited resources, must take steps towards realising the right to health and develop health policies that:</p> <ul style="list-style-type: none"> <li>• Ensure the rights to equality and non-discrimination, information and privacy;</li> <li>• Provide a minimum essential package of health services and facilities;</li> <li>• Have good systems for gathering and sharing information and carrying out health-related research;</li> <li>• Allow and encourage the participation of those affected by the decisions on health policy;</li> <li>• Respect cultural differences; and</li> <li>• Include accessible, transparent and effective accountability systems.</li> </ul>
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## Appendix 2. Sources and resources on the right to health

Organisation	Resource	Where to find it
Right to Health Unit, University of Essex, UK	Fact sheets, briefing papers and reports of the UN Special Rapporteur on the right to health (2002-2008).	<a href="http://www.essex.ac.uk/human_rights_centre/research/rth/index.aspx">www.essex.ac.uk/human_rights_centre/research/rth/index.aspx</a>
United Nations Office of the High Commissioner for Human Rights	<ul style="list-style-type: none"> <li>• Fact Sheet No. 31;</li> <li>• Various reports on right to health and other human rights.</li> </ul>	<a href="http://www.ohchr.org/Documents/Publications/Factsheet31.pdf">www.ohchr.org/Documents/Publications/Factsheet31.pdf</a> <a href="http://www.ohchr.org">www.ohchr.org</a>
Lawyers Collective	Reports and information regarding the work of UN Special Rapporteur on the right to health.	<a href="http://www.lawyerscollective.org">www.lawyerscollective.org</a>
Physicians for human rights	Reports on different aspects of health and human rights. Toolkits: use the search facility.	<a href="http://www.physiciansforhumanrights.org">www.physiciansforhumanrights.org</a>
Columbia University	Resources on maternal health.	<a href="http://www.amddprogram.org">www.amddprogram.org</a>
Centre for Reproductive Rights	Resources on reproductive rights.	<a href="http://www.crlp.org">www.crlp.org</a>
Francois Xavier Bagnoud Center for Health and Human Rights, Harvard University	Resources on health and human rights.	<a href="http://www.hsph.harvard.edu/xfbcenter">www.hsph.harvard.edu/xfbcenter</a>
Fundar	Resources on budget analysis.	<a href="http://www.fundar.org.mx">www.fundar.org.mx</a>
Economic Commission for Africa	Promoting Gender Equality and Women's Empowerment in Africa: Questioning the Achievements and Confronting the Challenges Ten Years After Beijing, Economic Commission for Africa, 2005.	
International Federation of Health and Human Rights Organisations	Fact sheets and briefing papers on health and human rights IFHHR/Huridocs: The Right to Health: A Resource Manual for NGOs.	<a href="http://www.ifhhro.org">www.ifhhro.org</a>  <a href="http://www.huridocs.org">www.huridocs.org</a>
United Nations Population Fund (UNFPA)	Resources on sexual and reproductive health.	<a href="http://www.unfpa.org">www.unfpa.org</a> <i>&gt; continued</i>

Organisation	Resource	Where to find it
The Joint UN Programme on HIV/AIDS (UNAIDS)	Resources on HIV/AIDS.	<a href="http://www.unaids.org">www.unaids.org</a>
World Health Organisation	Resources on health.	<a href="http://www.who.int">www.who.int</a>
International Initiative on Maternal Mortality and Human Rights	Resources on maternal health.	<a href="http://www.righttomaternalhealth.org">www.righttomaternalhealth.org</a>
Men Care	MenCare – A Global Fatherhood Campaign, coordinated by Promundo, Sonke and the MenEngage Alliance, as an effort to promote men’s involvement as fathers and as caregivers.	<a href="http://www.men-care.org">www.men-care.org</a>
MenEngage Alliance	MenEngage is a global alliance of NGOs and UN agencies that seeks to engage boys and men to achieve gender equality.	<a href="http://www.menengage.org">www.menengage.org</a>
White Ribbon Alliance for safe Motherhood	The White Ribbon Alliance for Safe Motherhood (WRA) is a nonpartisan, non-profit and non-governmental membership organisation that aims to decrease maternal and newborn death globally.	<a href="http://www.whiteribbonalliance.org">www.whiteribbonalliance.org</a>
The White Ribbon Campaign	Men working to end men's violence against women.	<a href="http://www.whiteribbon.ca">www.whiteribbon.ca</a>
Say NO – UNiTE to End Violence against Women	A global call for action. Say NO records what individuals, organisations and governments worldwide are doing to end violence against women.	<a href="http://www.saynotoviolence.org/">www.saynotoviolence.org/</a>
UNite to End Violence against Women Campaign	UNiTE to End Violence against Women campaign aims to prevent and eliminate violence against women and girls in all parts of the world.	<a href="http://www.endviolence.un.org/">www.endviolence.un.org/</a>
Women Deliver	Women Deliver is a global advocacy organization bringing together voices from around the world to call for action against maternal death.	<a href="http://www.womendeliver.org/">www.womendeliver.org/</a>

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Organisation	Resource	Where to find it
ICPD-Programme of Action (International Conference on Population and development)	<p>The United Nations coordinated an International Conference on Population and Development in Cairo, Egypt in 1994. Its resulting Program of Action is the steering document for the United Nations Population Fund (UNFPA). 197 countries achieved consensus on the following four qualitative and quantitative goals to be achieved by 2014:</p> <ul style="list-style-type: none"> <li>• Universal education;</li> <li>• Reduction of infant and child mortality;</li> <li>• Reduction of maternal mortality;</li> <li>• Access to reproductive and sexual health services including family planning.</li> </ul>	<a href="http://www.un.org/popin/icpd/conference/offeng/poa.html">www.un.org/popin/icpd/conference/offeng/poa.html</a>
Maputo plan of action	This is a document promoting Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa.	<a href="http://www.unfpa.org/africa/newdocs/maputo_eng.pdf">http://www.unfpa.org/africa/newdocs/maputo_eng.pdf</a>
The Continental Policy Framework on Sexual and Reproductive Health and Rights	The Continental Policy Framework on Sexual and Reproductive Health and Rights was adopted by the African Ministers of Health at the 2nd African Union Conference of Health Ministers held in Gaborone, Botswana in October 2005 and endorsed by the Summit of the African Heads of State and Government in Khartoum, Sudan in January 2006.	<a href="http://www.ippfar.org/NR/rdonlyres/OEAD868D-2E89-4D91-B661BCC971933AD8/0/Continental_Policy_Framework_English.pdf">www.ippfar.org/NR/rdonlyres/OEAD868D-2E89-4D91-B661BCC971933AD8/0/Continental_Policy_Framework_English.pdf</a>
CARMMA	The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an African Union Commission (AUC) and UNFPA initiative to intensify the implementation of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. Several United Nations agencies, bilateral donors and International Planned Parenthood Federation (IPPF) support CARMMA at the national, regional and global levels.	<a href="http://www.au.int/pages/carmma">www.au.int/pages/carmma</a>



## Appendix 3: NGOs and INGOs

Name of organisation	Description and contact information
Action Group for Health, Human Rights, and HIV/AIDS (AGHA)	HIV/AIDS and human rights Plot 69 Kanjokya Street PO Box 24667 Kampala, Uganda Phone: +256414348491
Africa Public Health Rights Alliance and the “15% Now!” Campaign	Africa Office: 17-19 Allen Avenue P.O Box 197 Ikeja Lagos, Nigeria Phone/Fax: +234 1 8197344 Email: <a href="mailto:africapublichealth@googlemail.com">africapublichealth@googlemail.com</a> Honorary Chair: Archbishop Desmond Tutu, 1984 Nobel Peace Prize winner
Africa Recruit Migration of health workers	Commonwealth Business Council 18 Pall Mall London SW1Y 5LU United Kingdom Phone: +442070248270
Catholics for Choice (CFC)	Catholics for Choice was founded in 1973 to serve as a voice for Catholics who believe that the Catholic tradition supports a woman’s moral and legal right to follow her conscience in matters of sexuality and reproductive health. Catholics for Choice produces a wide range of publications on the Catholic Right, Catholic health care, Catholic public opinion. Catholics for Choice 1436 U Street NW, Suite 301 Washington, DC 20009-3997 USA Office: +1 (202) 986-6093 Fax: +1 (202) 332-7995 Website: <a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>

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Name of organisation	Description and contact information
Centre for Human Rights University of Pretoria Human Rights Centre	Centre for Human Rights, Faculty of Law University of Pretoria Pretoria 0002 South Africa Phone: +27124202374
Family Care International	The first international organisation dedicated to maternal health, aiming at making pregnancy and childbirth safer around the world Family Care International 588 Broadway, Suite 503 New York, NY 10012, USA Phone and fax: +1 (212) 941-5300 and +1 (212) 941-5563 Email: <a href="mailto:contact@familycareintl.org">contact@familycareintl.org</a> Website: <a href="http://www.familycareintl.org">www.familycareintl.org</a>
Guttmacher Institute	An institute seeking to advance sexual and reproductive health through research, policy analysis and public education. Website: <a href="http://www.guttmacher.org">www.guttmacher.org</a>
Health Action International-Africa (Access to medicines and other health issues)	PO Box 66054-00800 Nairobi, Kenya Phone: 254-0203860434-6
Independent Medico-Legal Unit (IMLU)	Torture and health issues David Osieli Rd, Off Old Waiyaki Way, Westlands, Nairobi, Kenya Phone: 254-020-4456048
The International Confederation of Midwives (ICM)	Supports, advises and strengthens associations of midwives across the world. There are currently 108 national Midwives Associations that are members of ICM, representing 98 countries across every continent. Website: <a href="http://www.internationalmidwives.org">www.internationalmidwives.org</a>
International Federation of Health and Human Rights Organisations (IFHHRO) (mainly working on/with health professionals)	Website: <a href="http://www.ifhhro.org">www.ifhhro.org</a>
International Planned Parenthood Federation (IPPF)	A global service provider and a leading advocate of sexual and reproductive health and rights for all, with central office in London and regional offices in the region. <span style="float: right;">&gt; <i>continued</i></span>

Name of organisation	Description and contact information
	<p>IPPF Central Office                      4 Newhams Row, London                      SE1 3UZ                      Phone: +44 (0)20 7939 8200                      Fax: +44 (0)20 7939 8300                      Email: <a href="mailto:info@ippf.org">info@ippf.org</a>                      Website: <a href="http://www.ippf.org">www.ippf.org</a></p>
<p>International Planned Parenthood Federation Africa Region (IPPFAR)</p>	<p>One of Africa's leading non-governmental organisations working in reproductive health and rights with a network of Member Associations in 44 countries in sub-Sahara Africa.</p> <p>IPPF Africa Region                      Madison Insurance House                      Upper Hill Road/Ngong Road                      PO BOX 30234                      Nairobi 100, Kenya                      Phone: +254 (20) 2720 280 or (20) 2720 281 or (20) 2720 282                      Fax: +254 (20) 2714 968                      Email: <a href="mailto:info@ippfaro.org">info@ippfaro.org</a>                      Website: <a href="http://www.ippfar.org">www.ippfar.org</a></p>
<p>International Women's Health Coalition (IWHC)</p>	<p>IWHC leads global and local actions to secure every woman's right to a just and healthy life.</p> <p>333 Seventh Avenue, 6th floor                      New York, NY 10001 USA                      Phone and fax: +1 (212) 979-8500 and +1 (212) 979-9009                      Website: <a href="http://www.iwhc.org">www.iwhc.org</a></p>
<p>IPAS</p>	<p>Founded in 1973, IPAS is a global nongovernmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, Ipas works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies.</p> <p>P.O. Box 9990                      Chapel Hill, NC 27515 USA                      Phone: +1 (919) 967-7052 or +1 (800)334-8446 (toll-free in US)                      Fax: +1 (919) 929-0258                      Email: <a href="mailto:info@ipas.org">info@ipas.org</a>                      Website: <a href="http://www.ipas.org">www.ipas.org</a></p>

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Name of organisation	Description and contact information
MacArthur Foundation Funder	Plot 432 Yakubu Pam Street (Amma House) The Penthouse Opposite National Hospital Central Business District Abuja PO Box 4023, Garki Abuja, Nigeria Phone: 09-2348053, 2348054
Physicians for Human Rights-USA	2 Arrow Street, Suite 301 Cambridge, MA 02138, USA Phone: +1 (617) 301-4200
Population Action International (PAI)	Population Action International advocates for women and families to have access to contraception in order to improve their health, reduce poverty and protect their environment. PAI publishes interesting reports and research materials which can be used by organisations all over the world. Furthermore PAI supports the advocacy of local organisations in developing countries. Population Action International 1300 19th street, NW suite 200 Washington DC 20036-1624 USA Phone: +1 (202) 557-3400 Fax: +1 (202) 728-4177 Website: <a href="http://www.populationaction.org">www.populationaction.org</a>
Project Concern International	Prevention of disease, improving community health and sustainable development No. 9/B Chitemwiko Close, Kabulonga Box 32320 Lusaka, Zambia Phone: 00-260-211-266-232/ 264-579 / 265-868
Promundo	Brazil based NGO that works locally, nationally and internationally to promote gender equality and reduce violence against women, children and youth. Rua México, 31 / 1502 - Centro Rio de Janeiro - RJ - Brasil Cep. 20031-904 Phone/Fax: +55 (21) 2215-5216 Website: <a href="http://www.promundo.org.br">www.promundo.org.br</a>
Regional Focal Point Africa	C/o AGHA Uganda PO Box 24667 Kampala, Uganda Phone: +256 41 348491 Email: <a href="mailto:ifhbro@aghauganda.org">ifhbro@aghauganda.org</a>

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Name of organisation	Description and contact information
Rutgers WPF	<p>A centre of expertise on sexual and reproductive health and rights. Its activities are mainly carried out in the Netherlands, Africa and Asia. Its aim is to improve sexual and reproductive health and rights throughout the world. Rutgers WPF supports partner organisations and professionals in their work, increasing their expertise on sexuality.</p> <p>Oudenoord 176-178, 3513 EV Utrecht, The Netherlands            Phone: +31 (30) 2313431            Website: <a href="http://www.rutgerswpf.org">www.rutgerswpf.org</a></p>
Save Congo Health and human rights	<p>07 Avenue des figuiers            Bel air - Kampemba            Lubumbashi, Katanga            Democratic Republic of Congo            Phone: (243) 998 352 973</p>
Sonke Gender Justice Network	<p>A South Africa based NGO that works across Africa to strengthen government, civil society and citizen capacity to support men and boys to take action to promote gender equality, prevent domestic and sexual violence and reduce the spread and impact of HIV and AIDS.</p> <p>website: <a href="http://www.genderjustice.org.za/">www.genderjustice.org.za/</a></p>
South African Medical Association	<p>National Medical Association            PO Box 74789            Lynnwood Ridge 00400            Block F Castle Walk Corporate Park            Pretoria 0153 South Africa            Phone: 0027-124812044</p>
Zimbabwe Association of Doctors for Human Rights (ZADHR)	<p>Zimbabwean doctors working on health and human rights            6th Floor, Beverly Court, 100 Nelson Mandela Ave            Harare, Zimbabwe            Phone: +263-(0)4-708118, 251468, 705370, (0)912-260380</p>



## Appendix 4: The Millennium Development Goals and their progress in Africa

In 2000 world leaders agreed to fight poverty with renewed determination and, in 2001 formulated eight Millennium Development Goals (MDGs) to be reached in 2015. Health targets are prominent in Goals 4, 5 and 6, but all the others also relate to the right to health.

### The millennium development goals



**Goal 1:** Eradicate extreme poverty and hunger (a.o. reduce underweight of children)



**Goal 2:** Achieve universal primary education (education for girls also leads in the longer term to lower fertility and bringing down maternal mortality)



**Goal 3:** Promote gender equality and empower women (this leads in the longer term to lower fertility, lower maternal mortality, better health)



**Goal 4:** Reduce child mortality



**Goal 5:** Improve maternal health (since the MDG Summit in 2005 it has been formulated as “Achieving universal access to reproductive and sexual health services”. This result is important to reach other goals as well.)



**Goal 6:** Combat HIV/AIDS, malaria and other diseases



**Goal 7:** Ensure environmental sustainability (such as safe drinking water)



**Goal 8:** Develop a Global Partnership for Development (such as for the affordability of drugs).

The eight MDGs break down into **21 quantifiable targets** that are measured by **60 indicators**.

They focus on relatively “quick impact initiatives”, in order to obtain significant results and achieve the targets set for 2015. Most of the budget has been reserved for quick impact initiatives, that involve cost-effective technologies, for example, cheap and affordable medicines such as Anti-RetroViral Treatment for people living with HIV/AIDS and insecticide treated nets to prevent malaria. As a consequence MDG 6 has received relatively more attention: 6.6 million people are receiving ARV treatment, malaria is reduced with 50% in Sub-Saharan countries.

MDG 5 has showed least results so far. Achieving this MDG requires a well-functioning health system for skilled birth attendance and emergency obstetric care. Lack of skilled personnel, and hence moderate or poorly functioning of health systems, block progress. Universal access to family planning methods has the potential for quick impacts, but budgets for this have declined since 2000, compared to investments in MDG 6. Initiatives for MDG5 are fragmented and can not be reached unless more attention is given to MDGs 2 and 3.

MDGs have contributed to better data collection and more visibility in (lack of) progress. This information can be used for effective advocacy and political mobilisation. While these global targets may not be appropriate for each country, most countries have shown some progress. However, at a disaggregated level (by gender, regional or income distribution) there is still a lot of disparity. For example, in Kenya access to contraceptives has increased four times from 2000 to 2001, while for the lowest socio-economic quintile (fifth) of the population access has declined. This example shows that disaggregated data is essential for good advocacy and political mobilisation.

This summary is based on the article "*Sub Saharan Africa and the MDGs: the need to move beyond the 'quick impact model'*", published in *Reproductive Health Matters*, Vol 19, Issue 38, November 2011 pages 42-55.



## Appendix 5: Template for making your own checklist

There are two checklists in this booklet: one for Monitoring health facilities, goods and services and another for Monitoring underlying determinants of health. Sections 3.4, 3.5, 3.6, 3.7 and 3.8 contain starting points for other checklists.

Readers who wish to make checklists for other situations can use this template to design them. The checklists in this booklet and other booklets in the series on related rights can serve as examples and items from these checklists may, as appropriate, be included in new checklists.



### Objectives:

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Set clear objectives.

- Identify the problem
- In collaboration with the community, think about the problem you have identified and set two or three objectives for research that will allow you to identify actions to address the problem. For example, if the problem relates to young people not getting access to reproductive services you would need to find out whether these services are available, accessible, acceptable, affordable and of good quality. The second task would be to investigate the barriers to access.



### Tasks:

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Identify the tasks. These should include:

#### 1. **Participatory research into health care needs of the community**

This involves, for example:

- Finding out what the national and local laws say;
- Identifying the stakeholders whose opinions and experiences may provide useful information (note that information about individuals should be treated as confidential);
- Carrying out interviews or surveys among the target group to find out their needs or problems. Consider the needs of different members of the target group - girls, young men, people with disabilities etc.;
- Interviewing other relevant stakeholders; and
- Mapping the problem: are there particular groups or sub-groups or geographical areas or customary systems where the problems are greater?

Advice on these tasks is given in the Main Book, Part II, Sections: 3, 4, 5, 6.5 and 6.6.

**2. Monitoring the situation in terms of government obligations concerning the availability, accessibility, acceptability and quality of goods, services and facilities**

- Identify the facilities and services that are relevant to the problem;
- Identify people or institutions (for example government or NGO web sites) that can provide information;
- Ensure that all monitors understand what to look for in terms of accessibility, acceptability etc.;
- Assess the facilities and services in terms of accessibility, availability etc.; and
- Carry out any observations that may be necessary, for example to see some of the facilities.

**3. Analysing results and taking action**

- See the Main Book, Part II, Sections 1-3;
- Use the Planning Box in the Main Book, Appendix 1;
- Identify activities to address the problem; and
- Carry them out and evaluate the results.