Building on the Synergy between Health and Human Rights: A Global Perspective

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1. Introduction

Before human rights, there was altruism and after human rights there is altruism—the unselfish concern for the welfare of others. Altruism has been and remains an integral part of the beliefs, behaviors and practices of public health practitioners. But altruism means different things to different people. What human rights does for public health is to provide an internationally agreed upon framework for setting out the responsibilities of governments under human rights law as these relate to people's health and welfare.

Human rights as they connect to health should be understood, in the first instance, with reference to the description of health set forth in the preamble of the WHO Constitution, and repeated in many subsequent documents and currently adopted by the 191 WHO Member States: Health is a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[1]

This definition has important conceptual and practical implications, as it illustrates the indivisibility and interdependence of rights as they relate to health. Rights relating to autonomy, information, education, food and nutrition, association, equality, participation and non-discrimination are integral and indivisible parts of the achievement of the highest attainable standard of health, just as the enjoyment of the right to health is inseparable from other rights, whether categorized as civil and political, economic, social or cultural.[2] Thus, the right to the highest attainable standard of health builds on, but is by no means limited to, Article 12 of the International Covenant on Economic, Social and Cultural Rights.[3] It transcends virtually every single other right.

This paper highlights the long evolution that has brought health and human rights together in mutually reinforcing ways. It will summarize key dimensions of public health and of human rights and will suggest a manner in which these dimensions intersect in a framework of analysis and action. It will address these issues against the background of the progress being made by the World Health Organization towards defining its roles and functions from a health and human rights perspective.

2. When Health and Rights Had Not Yet Met

Until only a few years ago, public health and human rights were often considered as two distinct, almost antagonistic sets of principles and practices. Public health was understood to promote the collective physical, mental and social well-being of people—this, even if in order to

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[1] Constitution of the World Health Organization, adopted by the International Health Conference, New York, 19 June–22 July 1946, and signed on 22 July 1946 by the representatives of 61 States.

[2] Leary V, "The Right to Health," *Health and Human Rights*, 1 (1994): 28.

[3] Article 12, International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by United Nations General Assembly Resolution 2200 A(XXI), 1966. Entered into force on 3 January 1976 in accordance with article 27.

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achieve public health goals, individual freedom to choose, to behave or to act had to be sacrificed to the common good.

This was, and continues to be, exemplified by the principles and practices which have guided the control of such communicable diseases as tuberculosis, typhoid or sexually transmitted infections, where quarantine or other restrictions of rights have too often been imposed on affected individuals without any valid public health justification.

Public health abuses have also been exemplified by the excessive institutionalization of people with physical or mental impairments where alternate care and support approaches have not been considered. And far from uncommon is discrimination in the health care setting on the basis of health status, gender, race, color, language, religion or social origin, or any other attribute that can impact the quality of services provided to individuals by or on behalf of the State.

In contrast, human rights law has tended to bring into focus the relationship between the State—the first-line provider and protector of human rights—and individuals who hold their human rights simply for being human. Even though people hold these rights throughout their lives, they are nonetheless often constrained in their ability to fully realize these rights. Those who are most vulnerable to violations or neglect of their rights are also often those who lack the power to evidence this impact on their wellbeing, including their state of personal health.

From an advocacy perspective, until recently, claims for better fulfillment of civil and political rights have taken precedence over other rights—social, economic and cultural. Human rights advocates recognized the negative health impact of infringements on civil and political rights—best exemplified by torture and other forms of degrading treatment.[4] Yet many feared that broadening the spectrum of rights advocacy to encompass the multifarious dimensions of health and rights violations might dilute the issues and thereby weaken their claims. Thus, for a long time, health ignored rights and rights ignored health.

These two worlds remained apart until the 1980s, when reproductive health issues and, later, HIV/AIDS brought into light the true nature of the relationship between health and rights. This relationship was not antagonistic, but it was not neutral; it was, in fact, mutually reinforcing and synergistic.[5]

The fields of health and rights are illuminated today by their commonalties, no longer by their differences. It is now understood that both represent universal aspirations; both are obligations of governments towards their people; and each supports and requires the fulfillment of the other.

Through their practice and research, public health and human rights practitioners have the responsibility to further establish *how* and *to what extent* the promotion and protection of health and human rights interact. What they do *not* have to do is to show *why* both health and human rights are good for people. In the relentless quest for a world where the attainment of the highest standard of physical, mental and social well being necessitates, and reinforces, the dignity, autonomy and progress of every human being, the broad goals of health and human rights are universal and eternal. They give us direction for our understanding of humanity, and practical tools for use in our daily work.

3. Four Directions for Public Health Action

In May 2000, the World Health Assembly adopted a WHO Corporate Strategy. This strategy sets out a useful typology which can be used as the backbone for a WHO health and human rights strategy. The WHO Corporate Strategy addresses four directions for public health:

[4] Article 7, International Covenant on Civil and Political Rights, adopted and opened for signature, ratification and accession by United Nations General Assembly Resolution 2000 A(XXI), 1966. Entered into force on 23 March 1976 in accordance with article 49.

[5] Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg H, "Health and Human Rights," *Health and Human Rights* 1(1) (1994).

- **Reduce disease, disability and death** by getting information about who is healthy and who is not, and by applying proven methods of prevention, care and support.
- **Promote healthy lifestyles** where the risks imposed on individuals by the environment or by cultural or social constructs are recognized and acted upon.
- **Build health systems** that equitably improve health, respond to people's expressed needs, and are financially fair.
- **Promote the recognition of health dimensions of social, economic, environmental and development policies** to ensure that such policies and consequent programs contribute to the advancement of health.

The primary goal of the Corporate Strategy is to advance global public health through an enhanced interaction between the Organization and its Member States. It also aims to ensure that the Hippocratic dictum of "first and foremost, cause no harm" is applicable not only to individual but also public health practices.

If we consider each of these directions for public health through the lens of human rights, we discover how the lack of respect for human rights can shape our vulnerability to ill health and how, on the flip side, the promotion and protection of human rights can be as powerful as a vaccine. Take as an example the core human right of *non-discrimination* and the impact that violation or neglect of this right can have on the above-mentioned directions for public health.

Discrimination can impact directly on the ways that **morbidity, mortality and disability**—the burden of disease—are both measured and acted upon. In fact, the burden of disease itself *discriminates*: disease, disability and death are not distributed randomly or equally within populations, nor are their devastating effects within communities. Tuberculosis is exploding in marginalized communities. The AIDS epidemic is finding new vulnerable populations among the poor and those with unequal status in society, women in particular. Discrimination compounds the effects of poverty; it is at the root of disease and of premature death. The burden of disease is dependent on the unequal capacity of individuals to access information, understand the risks to which they have been exposed, and acquire the ability and freedom both to reduce these risks and to access preventive and care services when they are needed.

Ill health finds fertile ground in populations that live in the shadows of our societies and are, therefore, never counted. Acting positively about health and human rights implies recognizing who, in society, is at a disproportionate risk of ill health. Counting, and counting well, counting while protecting people's dignity and privacy, is the beginning of a successful approach towards better health and rights.

The year 2000 issue of the *World Health Report* applied a new set of indicators to help determine the profiles of national health systems around the world.[6] This report posed that health systems have three goals: achieving good health; enhancing responsiveness to the expectations of the population; and assuring fairness of financial contributions. For each of these goals, it proposed a composite indicator to assess the attainment and performance of each nation's health system. Two of the three indicators used in measuring attainment—health status and health system responsiveness—were subdivided so as to reflect overall national level and the disparity within each country. The notion of inequality was built intrinsically into the third indicator—fairness in financing. It is hoped that this new assessment method will stimulate countries to recognize the health differentials that national, aggregate measures can hide. As these indicators are further improved and become more "human rights sensitive," they may produce relevant evidence for a health and human rights analysis of health systems. Such an approach could, for example, seek to link disparities in health and health system performance between and within each nation with progress being achieved in the realization of human rights, for example the right to non-discrimination.

[6] World Health Organization: *The World Health Report 2000: Health Systems: Improving Performance* (Geneva, Switzerland: WHO, 2000).

Discrimination also affects **lifestyles**. The patterns of smoking in the world show the tobacco industry taking a new focus on those with limited access to information and education and those whose ability to choose and decide on matters related to their own health are limited by economic and social pressure. Around the world, lower income, lower education and lower purchasing power increasingly translate into higher rates of smoking and a higher probability of dying from it. Multinational companies marketing tobacco operate in a relative vacuum of international law. New ways have to be found to hold them accountable and for governments to fulfill the human rights obligations raised by this new challenge, including the rights of children to be protected against the promotion of harmful substance use.

Discrimination in **health systems**, including health centers, hospitals or mental institutions, may further contribute to exacerbating disparities in health. Think of migrant workers receiving poor or no treatment for fear of having to justify their civil status. Think of those who, for reasons of marginalization related to sexual identity or to behaviors considered to be "against social or cultural norms" are denied access to treatment available to other individuals. Think of immunizations or other essential care or procedures that are withheld from children and adults who are thought to be already affected by other illnesses considered incurable. Think of people with hemophilia who are given unsafe blood products on the premises that this adds only a "marginal" risk to their lives, and think of people with physical or mental disabilities receiving sub-standard care and unable to complain because their voices are not heard.

Discrimination in health systems concerns not only diseases that are already stigmatized, such as AIDS, tuberculosis and cancer, but also others, such as diabetes and cardiovascular diseases, which could be alleviated if *equal treatment* within societies and within health care settings became the norm.

Discrimination can also be at the root of unsound **human development policies and programs** that may impact directly or indirectly on health. For example, an infrastructure development project may require the displacement of entire populations and fail to pay sufficient attention to the new environment to which these populations will have to adjust. In the developing world, the impact of large-scale development programs at the local level is often considered from the perspective of the possible further spread of such infectious diseases as malaria and other water-born diseases. The psychological capacity of displaced communities to relocate and rebuild new lives, or the long-term physical and social consequences of such displacement, are seldom factored into the equation.

The impact of discrimination on health, whether perpetrated, condoned or tolerated by the State, is but one—although perhaps the most visible—representation of the health impact of the violation or neglect of human rights. But there are many other ways, far more subtle, in which health and rights interact.

We have known for decades that one of the strongest determinants of child health and survival is the level of educational attainment of the child's mother. Yet inequality remains in the ability of boys and girls to enroll in schools and complete primary education—although most governments in the world have ratified treaties guaranteeing the right of everyone to education.[7] To educate children works towards better health. To protect their health is essential for them to achieve better education and prepare them better for their lives. Health and human rights converge in the present as they do in the future.

Human rights and health act in synergy when dignity and privacy are protected and when people can confide in a health system that listens to them and responds to their needs, without prejudice or arbitrary judgement. The convergence of health and rights is in sight when health policies are informed by, and respectful of human rights and dignity. Central to the responsiveness of health systems to people's needs is the concept of dignity. Respect for dignity is often challenged by overburdened health systems where time for treating disease seems to compete with time for treating patients. Dignity is a hard-to-define concept. However, as the late Jonathan Mann used to remind us,

[7] Article 13, International Covenant on Economic, Social and Cultural Rights.

we may find it difficult to define dignity, but we know immediately what it is once our own dignity has been offended.[8]

4. Three Sets of Governmental Obligations with Respect to Human Rights

Along with the entire United Nations system, the World Health Organization is in the process of integrating human rights into its work. For each of the UN agencies, this means analyzing what they do and do not do in relation to their human rights obligations to respect, protect and fulfill human rights in their policies, programs and practices. For WHO, it means defining its global public health responsibilities and role from a health and human rights perspective and drawing a new action and research agenda. The process of integrating health and human rights, currently underway at WHO, requires the development of a strategy that builds on its existing Corporate Strategy. Its effectiveness is likely to involve conceptual and procedural changes as well capacity building within the Organization itself and among its Member States.

The construct of a WHO health and human rights strategy may arise from the recognition of three sets of human rights obligations, in particular as these apply to States and to the UN system, in this particular instance with regards to health:[9,10]

- Governments have the obligation to **respect** human rights, which requires governments to refrain from interfering directly or indirectly with the enjoyment of human rights. In practice, no health practice, policy, program or legal measure should violate human rights. The provision of health services should be ensured to all population groups on the basis of equality and freedom from discrimination, paying particular attention to vulnerable and marginalized groups.
- Governments have the obligation to **protect** human rights, which requires governments to take measures that prevent non-state actors from interfering with human rights. In practice, Governments should acquire an enhanced capacity to analyze health-related actions or inactions attributable to non-state actors on the national and international levels, and act accordingly. This relates to such important non-state actors as private health care providers, health insurance companies and, more generally, the health-related industry.
- Governments have the obligation to **fulfill** human rights, which requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of human rights. In practice, Governments should be supported in their efforts to develop and apply these measures and monitor their impact, with an immediate focus on vulnerable and marginalized groups.

5. Applying the Right to Health

As this work has been progressing, in May 2000, the Committee on Economic, Social and Cultural Rights adopted a General Comment on Article 12 of the International Covenant on

[8] "The definition of dignity itself is complex and thus far elusive and unsatisfying. While the Universal Declaration of Human Rights starts by placing dignity first … we do not yet have a vocabulary or taxonomy, let alone an epidemiology of dignity violations. Yet it seems we all know when our dignity is violated or impugned." Cited from Jonathan Mann; "Medicine and Public Health, Ethics and Human Rights," in: Mann JM, Gruskin S, Grodin MA and Annas GJ, eds., *Health and Human Rights: A Reader* (New York: Routledge, 1999), pp. 439–52.

[9] Eide A, "Economic, Social and Cultural Rights as Human Rights," in: Eide A, Krause C, Rosas A, eds., *Economic, Social and Cultural Rights: A Textbook* (Dordrecht: M. Nijhoff, 1995), pp. 21–40.

[10] Toebes B., The Right to Health as a Human Right in International Law, School of Human Rights Research Series, vol. 1, INTERSENTIA-HART, 1999.

Economic, Social and Cultural Rights: the right to the highest attainable standard of health.[11] It is a solid document that will, over time, contribute to the understanding, actions and accountability of States under international human rights law and their health-related obligations.[12] The General Comment lays out directions for the practical application of Article 12 and a monitoring framework. It may be worth commenting briefly here on three selected aspects of the document that have important implications for public health practice: progressive realization; limitations of rights in the interest of public health; and monitoring the application of health and human rights principles by Member States and the United Nations.

Progressive Realization of the Right to Health

In all countries, resource and other constraints can make it impossible for a government to fulfill all rights immediately and completely. The principle of "progressive realization" is fundamental to the achievement of human rights as they apply to health.[13] This is critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible. It is of equal relevance to wealthier countries in that they are responsible for respecting, protecting and fulfilling human rights not only within their own borders, but also through their engagement in international assistance and cooperation.

The Director-General of WHO, Gro Harlem Brundtland, has cited the need to integrate efforts towards this goal, noting: "Even when governments are well-intentioned, they may have difficulty fulfilling their health and human rights obligations. Governments, the WHO and other intergovernmental agencies should strive to create the conditions favorable to health, even in situations where the base of public finance threatens to collapse."[14]

The 1978 Declaration of Alma-Ata called on nations to ensure the availability of the essentials of primary health care (PHC), including: education concerning health problems and the methods for preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs.[15] While the current delineation of PHC elements may provide for the initial core obligations of the right to health, progressive realization requires reexamination of governmental obligations as they are fulfilled and health needs and technologies evolve. [16]

The ambitious and constantly advancing objectives of health development must be examined keeping in mind the role of governments in ensuring equal and equitable access to medical care and health promotion while striving, within available resources, to create the underlying conditions necessary for health. Given that the advancement of health necessitates infrastructure and human

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[11] General Comment 14 on the Right to the Highest Attainable Standard of Health; drafted under the leadership of Pr Eibe Riedel, Rapporteur to the UN Committee on Economic, Social and Cultural Rights; Geneva, Switzerland, 20 May 2000.

[12] Analyzing the normative content of the right to the highest attainable standard of health, the draft general comment distinguishes between four essential features of health services: (a) Availability essentially provides that governments have a responsibility to ensure that prevention and care facilities, including infrastructures, skilled human resources, goods and services are in place and appropriately funded; (b) Accessibility brings forward the government obligation to ensure these to all; (c) Acceptability implies that the services provided are designed and delivered in such ways that the intended beneficiaries feel comfortable in using them and that their dignity and privacy are protected and respected; and (d) Quality of services requires that these services are scientifically sound and conform to public health "best practice."

[13] Article 2, International Covenant on Economic, Social and Cultural Rights.

[14] Gro Harlem Brundtland, Director General of the World Health Organization, "Fifty Years of Synergy Between Health and Rights," *Health and Human Rights*, 3(2) (1998): 21–25.

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

[16] This need was reflected in the World Health Declaration adopted by the Fifty-first World Health Assembly, WHA51.5 (Geneva, May 1998) which adapted and extended the initial elements of primary health care to include expanding options for immunization; reproductive health needs; provision of essential technologies for health; health promotion, prevention and control of non-communicable diseases; food safety and provision of selected food supplements.

and financial resources that may not match existing or future needs in any country, the principle of progressive realization takes into account the inability of Governments to meet their obligations overnight. Yet, it creates an obligation on Governments to show how and to what extent they are achieving progress towards health goals they have agreed to in international fora such as the World Health Assembly, and those they have set additionally for themselves.

Human Rights Limitations in the Interest of Public Health

There are situations where it is considered legitimate to limit rights in order to achieve a broader public good. As described in the International Covenant on Civil and Political Rights, the public good can take precedence to: "secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation."[17]

Public health is a public good that may justify the limitation of certain rights under certain circumstances. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease—for example, Ebola fever, syphilis, typhoid or untreated tuberculosis—is an example of a limitation on rights that may be necessary for the public good and therefore may be considered legitimate under international human rights law. Yet arbitrary restrictive measures taken by public health authorities that fail to consider other valid alternatives may be found to be both abusive of human rights principles and in contradiction with public health "best practice." The public health response to the HIV/AIDS pandemic revealed that the sorts of restrictive measures traditionally applied to epidemic control are generally ineffective or even counter-productive.

If the limitation of certain rights in the interest of public health remains an option under both international human rights law and public health laws, the decision to impose such limitations must be achieved at through a structured process. The limitations under consideration must be in the interest of a legitimate objective of general interest. It must be in accordance with the law and strictly necessary in a democratic society to achieve the objective. There should be no less intrusive and restrictive means available to reach the same objective; and it should not be imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.[18]

Monitoring Health and Human Rights

Mention has been made earlier of the ongoing development of indicators of health *outcome* (e.g. morbidity, mortality, disability rates) and health system performance which, by providing national and sub-national data, create new opportunities for enhancing governmental ability to assess and report on progress achieved towards realizing human rights in conformity with international human rights law.[19] Yet indicators of disease burden or of performances of health systems may not translate fully a Government's commitment or capacity to promote and protect human rights in relation to health.

Equally relevant to the monitoring of health and human rights are indicators reflecting compliance with health and human rights principles of the *processes* of policy and program development. For example, through appropriately designed indicators and monitoring systems, the State should be able to show evidence that efforts towards collecting and analyzing data do not discriminate against any population groups. It should be able to show that the process of policy development, program design and resource allocation was/is inspired by, and respectful of, human rights principles, including participation, equality and non-discrimination.

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[17] Article 4, International Covenant on Civil and Political Rights.

[18] The Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights, Annex to UN Doc. E/CN.4/1985/4 of 28 September 1984.

[19] Article 16, International Covenant on Civil and Political Rights.

International accountability of the United Nations system and of its Member States on both selected outcome and process indicators would provide a clearer representation of the efforts developed to progress in health and human rights terms, and within the specific context of available structures, environmental constraints and resources.[20] The dual emphasis on outcome and process monitoring is particularly relevant here, as a long interval may separate the time when chosen measures are taken from the time their impacts begin to be felt.

6. The Convergence of Health and Rights: From Concept to Action

By combining the four directions of public health and the three sets of governmental obligations with respect to human rights, an analytical and action-oriented framework begins to emerge.[21] (See Table 1.) This framework builds on each of the four dimensions of public health: disease and impact reduction, promotion of healthy lifestyles, strengthening of health systems and human development policies informed by health. Intersecting with each of these directions are the three human rights obligations: to respect human rights (not to violate rights), to protect human rights (to be attentive to non-state actors) and to fulfill human rights (to take measures to promote human rights and establish redress mechanisms). The issues presented in Table 1 are not meant to be highly detailed, but simply to serve as examples of the points of convergence between health and rights this approach brings to light.

Each of the intersections between the four directions of public health and the three dimensions of human rights obligations are rich in questions and suggestive of specific actions. These actions include the development of adequate monitoring tools reflecting both health and human rights concerns; the application of health and human rights principles to policy development and practices; and the creation of a significant research agenda to advance our collective understanding of the health and human rights relationship.

The framework can be applied to define the roles and responsibilities of WHO in health and human rights, as well as the technical support the Organization needs to extend to its Member States to reinforce their capacity to translate their commitments under international human rights law into effective health policies and actions. Although it is intended primarily to guide the development of a WHO strategy on health and human rights, a similar analytical framework can be applied to recognition of the points of convergence between health and rights in specific public health domains such as the design of an approach to disease control. The analysis can begin by identifying public health options for effective disease control and, using the three sets of governmental obligations with respect to human rights, consider which intervention achieves the highest results in both health and human rights terms.[22]

People engaged in the promotion or protection of human rights may begin their analysis by examining a specific right and seeking how, and to what extent the violation or the lack of realization of this right may impact on health.

These analyses will be most effective if done in partnership between public health practitioners and people with substantive knowledge of human rights. This partnership will foster a clearer understanding of the synergy between health and human rights and provide additional impetus to Governments to undertake policies, programs and actions that best serve public health while contributing to the advancement of human rights.

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[20] Tarantola D: Presentation on behalf of WHO on the General Comment on the Right to the Highest Attainable Standard of Health, before the Committee on Economic, Social and Cultural Rights, United Nations High Commission for Human Rights, Palais Wilson, Geneva, Switzerland, 8 May 2000.

[21] Gruskin S, Tarantola D, "Health and Human Rights," in: *The Oxford Textbook of Public Health* (Oxford University Press, in press).

[22] Gostin L, Mann J: Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies. In: *Health and Human Rights: A Reader*, Mann J, Gruskin S, Grodin M, Annas G eds; Routledge, (1999), 54-71.

Table 1. A Pathway to Health and Human Rights

Domains of health	Governmental obligations with respect to human rights		
	Respect	**Protect**	**Fulfill**
1. Reduce morbidity, disability and mortality	Government not to violate rights of people on the basis of their health status including in information collection and analysis, as well as in the design and provision of health and other services.	Government to prevent non state actors (including private health care structures and insurance providers) from violating the rights of people on the basis of their health status including in the provision of health and other services.	Government to take administrative, legislative, judicial and other measures to promote and protect the rights of people regardless of their health status, including the generation of data concerning health outcomes for use in guiding health policies and the provision of health and other services, as well as providing legal means of redress that people know about and can access.
2. Promote healthy lifestyles	Government not to violate rights, in particular those violations which result in, or perpetuate, lifestyles associated with increased morbidity, mortality, disability.	Government to prevent non-state from human rights violations, in particular those which result in, or perpetuate lifestyles associated with increased morbidity, mortality, disability.	Government to take administrative, legislative, judicial and other measures including sufficient resource allocation to ensure that healthy lifestyles are promoted, and provision of legal means of redress as applicable.
3. Strengthen health systems	Government not to violate rights directly in the design, implementation and evaluation of national health systems, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality for all members of the population.	Government to prevent non-state actors (including private health care structures and insurance providers) from violating rights in the design, implementation and evaluation of health systems and structures, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality	Government to take administrative, legislative, judicial and other measures including sufficient resource allocation and the building of safety nets, to ensure that health systems are sufficiently accessible, efficient, affordable and of good quality, as well as providing legal means of redress that people know about and can access.

Continued on following page

4. Develop health-sensitive policies and programs	Government not to violate the civil, political, economic, social and cultural rights of people directly, recognizing that neglect or violations of rights impact directly on health.	Government to prevent rights violations by non-state actors, recognizing that neglect or violations of rights impact directly on health.	Government to take all possible administrative, legislative, judicial and other measures, including the promotion of human development mechanisms, towards the promotion and protection of human rights, as well as providing legal means of redress that people know about and can access.