institution (ECHR, Article 5 (1) (e); UN Mental Illness Principles, Principle 16). However, because involuntary detention is an extremely serious interference with the freedom of persons with disabilities, in particular their right to liberty and security, international and national human rights law attaches numerous procedural safeguards to involuntary detention cases. Moreover, these safeguards are generating a significant jurisprudence, most notably in regional human rights commissions and courts (ECtHR 1979; Gostin & Gable 2004; Gostin 2000; Lewis 2002).

Entitlements

The right to health includes an entitlement to a system of health protection which provides equality of opportunity for all people to enjoy the highest attainable standard of health through access to both healthcare and the underlying determinants of health, all of which play a vital role in ensuring the health and dignity of persons with mental disabilities (UNGA 1993, Rules 2–4).

States are required to take steps to ensure a full package of community-based mental healthcare and support services conducive to health, dignity, and inclusion. These should include medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programmes to maximize the independence and skills of persons with intellectual disabilities, supported housing and employment, income support, inclusive and appropriate education for children with intellectual disabilities, and respite care for families looking after a person with a mental disability 24 h a day. In this way, unnecessary institutionalization can be avoided.

Scaling up interventions to ensure equality of opportunity for the enjoyment of the right to health requires that adequate numbers of appropriate professionals be trained. Similarly, primary care providers should be provided with essential mental healthcare and disability sensitization training to enable them to provide front-line mental and physical healthcare to persons with mental disabilities.

Underlying determinants of health that are particularly relevant to persons with mental disabilities, who are disproportionately affected by poverty and as such often deprived of important entitlements, include adequate sanitation, safe water, and adequate food and shelter (UNCESCR 2000, para. 4). The conditions in psychiatric hospitals, as well as other institutions used by persons with mental disabilities, are often grossly inadequate from this point of view.

◆ *Obligations of immediate effect and progressive realization*

It is reasonable to expect that countries, even those with very limited resources, undertake to implement certain measures towards realization of the right to health for people with disabilities. For example they can be expected to: Include the recognition, care, and treatment of mental disabilities in training curricula of all health personnel; promote public campaigns against stigma and discrimination of persons with mental disabilities; support the formation of civil society groups that are representative of mental healthcare users and their families; formulate modern policies and programmes on mental disabilities; downsize psychiatric hospitals and, as far as possible, extend community care; in relation to persons with mental disabilities, actively seek assistance and cooperation from donors and international organizations (WHO 2001b, pp. 112–15).

◆ *Respect, protect, fulfil*

Specifically in relation to mental disabilities, the obligation to *respect* requires States to refrain from denying or limiting equal access to healthcare services and underlying determinants of health, for persons with mental disabilities. They are also required to ensure that persons with mental disabilities in public institutions are not denied access to healthcare and related support services, or underlying determinants of health, including water and sanitation (IACHR 1997).

The obligation to *protect* means that States are required to take actions to ensure that third parties do not harm the right to health of persons with mental disabilities. For example, States should take measures to protect persons with mental disabilities from violence and other right to health-related abuses occurring in private healthcare or support services.

The obligation to *fulfil* requires States to recognize the right to health, including the right to health of persons with mental disabilities, in national political and legal systems, with a view to ensuring its implementation. States should adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards this end (ICESCR Article 2(1); UNCESCR 2000, para. 36). For example, States should ensure that the right to health of persons with mental disabilities is adequately reflected in their national health strategy and plan of action, as well as other relevant policies, such as national poverty reduction strategies, and the national budget (WHO 2004c). Mental health laws, policies, programmes, and projects should embody human rights and empower people with mental disabilities to make choices about their lives; give legal protections relating to the establishment of (and access to) quality mental health facilities, as well as care and support services; establish robust procedural mechanisms for the protection of those with mental disabilities; ensure the integration of persons with mental disabilities into the community; and promote mental health throughout society (WHO 2005a). Patients' rights charters should encompass the human rights of persons with mental disabilities. States should also ensure that access to information about their human rights is provided to persons with mental disabilities and their guardians, as well as others who may be institutionalized in psychiatric hospitals.

◆ *International assistance and cooperation*

The record shows that mental healthcare and support services are not a priority health area for donors. Furthermore, donors have sometimes supported inappropriate programmes, such as the rebuilding of a damaged psychiatric institution constructed many years ago on the basis of conceptions of mental disability that have since been discredited. In so doing, the donor inadvertently prolongs, for many years, seriously inappropriate approaches to mental disability.

It is unacceptable for a donor to fund a programme that, in moving a psychiatric institution to an isolated location, makes it impossible for its users to sustain or develop their links with the community (MDRI 2002). If a donor wishes to assist children with intellectual disabilities, it might wish to fund community-based services to support children and their parents, enabling the children to remain at home, instead of funding new facilities in a remote institution that the parents can only afford to visit once a month, if at all (Rosenthal 2000).

Donors have a right to health duty to consider more—and better quality—support in the area of mental disability. In accordance with their responsibility of international assistance and cooperation, they are required to consider adopting measures such as: Supporting the development of appropriate community-based care and support services; supporting advocacy by persons with mental disabilities, their families and representative organizations; and providing policy and technical expertise. Furthermore, donors should ensure that all their programmes promote equality and non-discrimination for persons with mental disabilities, while international agencies fulfil the role that corresponds to them by providing technical support.

◆ *Monitoring and accountability*

The right to health requires that States have in place effective, transparent, and accessible monitoring and accountability mechanisms in relation to the health of persons with mental disabilities.

In many countries, there is an absence of sustained and independent monitoring of mental healthcare, resulting in frequent abuses in large psychiatric hospitals and community-based settings going unnoticed. The Mental Illness Principles emphasize the importance of inspecting mental health facilities, as well as investigating and resolving complaints where an alleged violation of the rights of a patient is concerned (UN Mental Illness Principle 22).

Lack of surveillance is doubly problematic because persons with mental disabilities, especially those who are institutionalized, are often unable to access independent and effective accountability mechanisms when their human rights have been violated. Where accountability mechanisms do exist, the severity of their condition may render them unable to protect their interests independently through legal proceedings, to demand effective procedural safeguards where these may be lacking, or to access legal aid.

For example, the right to health requires that an independent review body must be made accessible to persons with mental disabilities, or other appropriate persons, to review cases of involuntary admission and treatment periodically (UN Mental Illness Principle 17).

Although there is a range of detailed international standards concerning the human rights of persons with mental disabilities, and procedural safeguards to protect them (UN Mental Illness Principles 11, 18), their lack of implementation poses a real challenge. The new Convention on the Rights of Persons with Disabilities will be crucial to international monitoring and accountability, especially if its Optional Protocol, which introduces a procedure under which individuals and groups can lodge complaints, were to come into force. Significantly, this mechanism strengthens the existing standards relating to the right to health of persons with mental disabilities that do not establish specific monitoring or accountability mechanisms.

Alongside this Convention, other international human rights treaties (including ICESCR, CRC, CEDAW and CERD, and ICCPR,) extend protections to persons with mental disabilities. For this reason, States should pay greater attention to them in their State party reports, and examination of these reports by the human rights treaty bodies should, in turn, give a greater focus to these issues through their discussions with States parties, concluding observations, and general comments or recommendations. Relevant civil society organizations, including representatives of persons with mental disabilities, play an important role by engaging with UN treaty bodies and special procedures.

Sexual and reproductive health, including maternal mortality

The Commission on Human Rights confirmed in 2003 that 'sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UNCHR 2003b, preamble and para. 6). The outcomes of world conferences, in particular the International Conference on Population and Development (UN 1994), the Fourth World Conference on Women (UN 1995), and their respective 5-year reviews, confirm that human rights have an indispensable role to play in relation to sexual and reproductive health issues.

More recently, there has been a deepening conceptual understanding of maternal mortality as a human rights issue (Cook *et al.* 2006; Freedman 2003). Although the issue is connected to a number of human rights, the right to the highest attainable standard of health is of particular relevance, and is the focus of the following remarks.

◆ *Freedoms and entitlements*

Freedoms

In the context of sexual and reproductive health, freedoms include a right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilization and forced abortion), female genital mutilation/cutting (FGM/C), and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are therefore fundamentally and inherently inconsistent with the right to health. In the specific context of maternal mortality, relevant freedoms include freedom from discrimination; harmful traditional practices, such as early marriage and violence.

For example, some cultural practices, including FGM/C, carry a high risk of disability and death. This means that where the practice exists, States should take appropriate and effective measures to eradicate it, in accordance with their obligations under the Convention on the Rights of the Child. Early marriage, which disproportionately affects girls, is predominantly found in South Asia and sub-Saharan Africa, where over 50 per cent of girls are married by the age of 18. Among other problems, early marriage is linked to health risks including those arising from premature pregnancy. Finally, in the context of adolescent health, States are obliged to set minimum ages for sexual consent and marriage (UNCRC 2003, paras. 9, 19).

Entitlements

Entitlements that form part of the rights to reproductive and sexual health include equal access, in law and fact, to reproductive and child health services, as well as information about sexual and reproductive health issues.

Specifically, States are required to provide a wide range of appropriate and, where necessary, free sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services, and access to information. They should also ensure access to such essential health services as voluntary testing, counselling, and treatment for sexually transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment.

Unsafe abortions kill some 68 000 women each year, and thus constitute a right to life and right to health issue of enormous proportions. They also give rise to high rates of morbidity.

Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: Public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible (WHO 2003). In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions are inconsistent with the right to the highest attainable standard of health.

Certain entitlements envisaged in international law are directly relevant to reducing maternal mortality (CEDAW Article 12 (2); UNCESCR 2000, para. 14) and, if fulfilled, would reduce its incidence. For example, an equitable, well-resourced, accessible, and integrated health system—a crucial entitlement arising from the right to health—is widely accepted as a vital pre-condition for guaranteeing women's access to the interventions that can prevent or treat the causes of maternal deaths (Freedman 2005). Other entitlements include education and information on sexual and reproductive health (UNCEDAW 1999a, para.18), safe abortion services where not against the law,[15] and primary healthcare services (UNCESCR 2000, paras. 14, 21; UNCEDAW 1999a para. 27; UN 1994, para. 8.25) especially universal access to reproductive healthcare (UNMP 2005b).

The entitlement to specific underlying determinants of health relevant to maternal mortality must also be guaranteed. The failure to safeguard women's rights is often manifested in low status of women, poor access to information and care, early age of marriage, and restricted mobility, among other problems (DFID 2005). Specifically, gender equality[16] has an important role to play in preventing maternal mortality as alongside empowerment it can lead to greater demand by women for family planning services, antenatal care, and safe delivery. Another relevant determinant of health and element of the right to health that must be ensured in order to address problems of maternal mortality is water and sanitation, which are vital to the provision of prenatal care and emergency obstetric care.

◆ *Available, accessible, acceptable and good quality*

In many countries, information on sexual and reproductive health is not readily available and, if it is, it is not accessible to all, in particular women and adolescents. Sexual and reproductive health services are often geographically inaccessible to communities living in rural areas, or provided in a form that is not culturally acceptable to indigenous peoples and other non-dominant groups. Similarly, services, and relevant underlying determinants of health, such as education, are often of substandard quality.

In order to address the problem of maternal mortality, the concept of availability calls for collective action to enhance care and improve human resource strategies, including increasing the number and quality of health professionals and improving terms and conditions (UNMP 2005c). Accessibility considers whether physical access and the cost of health services influence women's ability to seek care (UNMP 2005c). Furthermore, discriminatory laws, policies, practices, and gender inequalities prevent women and adolescents from accessing good quality services or information on sexual and reproductive health, and have a direct impact on maternal mortality (Cook *et al.* 2006). To prevent maternal mortality, scaling up technical interventions, or making the interventions affordable is insufficient: Strategies ensuring the *acceptability* of services through their sensitivity to the rights, cultures and needs of pregnant women, including those from indigenous peoples and other minority groups, are also vital (Shiffman 2006). Quality of care will influence both a woman's decision whether or not to seek care, as well as the outcome of interventions, and so is key to tackling maternal mortality through the provision of maternal healthcare services.

◆ *Discrimination, vulnerability and stigma*

Discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds, e.g. gender, race, poverty, and health status (UNCHR 2003a, para. 62).

Discrimination based on gender hinders the ability of many women to protect themselves from HIV infection and to respond to the consequences of HIV infection. Women and girls' vulnerability to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education, and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.

Stigma and discrimination associated with HIV/AIDS may also reinforce other prejudices, discrimination, and inequalities related to gender and sexuality. The result is that those affected may be reluctant to seek health and social services, information, education, and counselling, even when those services are available. This, in turn, will contribute to the vulnerability of others to HIV infection.

Vulnerability in the context of sexual and reproductive health is particularly relevant to adolescents and young people, who find themselves lacking access to relevant information and services during a period characterized by sexual and reproductive maturation. Important protections for adolescents are enshrined in CRC, which includes a number of cross-cutting principles which have an important bearing on adolescent's sexual and reproductive health, namely: The survival and development of the child, the best interests

[15] UN human rights bodies have also held that absolute legal prohibitions on abortion can violate the rights to life and health where they contribute to maternal mortality. For example, in its Concluding Observations on Colombia, CEDAW noted, with great concern: 'That abortion, which is the second cause of maternal deaths in Colombia, is punishable as an illegal act. No exceptions are made to that prohibition, including where the mother's life is in danger or to safeguard her physical or mental health or in cases where the mother has been raped. . . . The Committee believes that legal provisions on abortion constitute a violation of the rights of women to health and life and of article 12 of the Convention' (UN CEDAW 1999b, para. 393).

[16] States should 'take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning' (CEDAW, article 12.1).

of the child, non-discrimination, and respect for the views of the child (CRC Articles 2,3,5,6,12; UNCRC 2003, para.12).

Discrimination on the grounds of sexual orientation is impermissible under international human rights law. The legal prohibition of same-sex relations in many countries, in conjunction with a widespread lack of support or protection for sexual minorities against violence and discrimination, impedes the enjoyment of sexual and reproductive health by many people with lesbian, gay, bisexual, and transgender identities or conduct.[17] Similarly, criminalization can impede programmes which are essential to promoting the right to health and other human rights.[18]

Arising from their obligations to combat discrimination, States have a duty to ensure that health information and services are made available to vulnerable groups. For example, they must take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. They must take action to redress gender-based violence and ensure that there are sensitive and compassionate services available for the survivors of gender-based violence, including rape and incest. States should ensure that adolescents are able to receive information, including on family planning and contraceptives, the dangers of early pregnancy, and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health. Consistent with *Toonen v. Australia* and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual people. It is also important to ensure that voluntary counselling, testing, and treatment of sexually transmitted infections are available for sex workers (UNHRCttee 1994).

Finally, in the context of sexual and reproductive health, breaches of medical confidentiality may occur. Sometimes these breaches, when accompanied by stigmatization, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault, and other abuse. Also, a lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being. States are obliged to take effective measures to ensure medical confidentiality and privacy.

Water and sanitation

Healthcare attracts a disproportionate amount of attention and resources. Yet access to water and sanitation, as well as other underlying determinants of health, are integral features of the right to the highest attainable standard of health.

- *Available, accessible, acceptable and quality*

Available

The right to health requires a State to do all it can to ensure that safe water and adequate sanitation is available to everyone in its jurisdiction. The quantity of water available for each person should correspond to the quantity specified by WHO (Howard & Bartram 2002), though some individuals and groups may require additional water due to health, climate, and work conditions, and the State should therefore ensure that this is also available. The right to health stipulates that States must ensure the availability of safe water for personal and domestic uses such as 'drinking, personal sanitation, washing of clothes, food preparation, personal and household hygiene' (UNCESCR 2003 para 12 (a)).

Accessible

The right to health also requires that water and sanitation be accessible to everyone without discrimination. In this context, accessibility has four dimensions:

First, water and sanitation must be within safe physical reach for all sections of the population, in all parts of the country. Water and sanitation therefore should be *physically accessible* within, or in the immediate vicinity of, the household, educational institution, workplace, and health or other institution (UN 2005, guideline 1.3). The inaccessibility of water within safe physical reach can seriously impair health, including the health of women and children responsible for carrying water. Carrying heavy water containers for long distances can cause fatigue, pain, and spinal and pelvic injuries, which may lead to problems during pregnancy and childbirth. Similarly, the absence of safe, private sanitation facilities subjects women to a humiliating, stressful, and uncomfortable daily routine that can damage their health (UNMP 2005a, pp. 23–5). When designing water and sanitation facilities in camps for refugees and internally displaced persons, special attention should be given to prevent gender-based violence. For example, facilities should be provided in safe areas near dwellings (UNHCR 2005).

Second, water and sanitation should be *economically accessible*, including to those living in poverty. Poverty is associated with inequitable access to health services, safe water, and sanitation. If those living in poverty are not enjoying access to safe water and adequate sanitation, the State has a duty to take reasonable measures that ensure access to all.

Third, water and sanitation should be *accessible* to all *without discrimination* on any of the grounds prohibited under human rights law, such as sex, race, ethnicity, disability, and socioeconomic status.

Finally, reliable *information* about water and sanitation must be *accessible* to all so that they can make well-informed decisions.

Acceptable

The right to health requires that water and sanitation facilities be respectful of gender and life-cycle requirements and be culturally *acceptable*. For example, measures should ensure that sanitation facilities are mindful of the privacy of women, men, and children.

Quality

Both water services and sanitation facilities must be of good *quality*: This reduces susceptibility to anaemia, diarrhoea, and other conditions that cause maternal and infant mortality and morbidity (UNMP 2005a, p. 18). Water required for personal and domestic use should be safe and free from 'micro-organisms, chemical substances and radiological hazards which constitute a threat to a person's health' (UNCESCR 2003, para. 12(b)). States should establish water quality regulations and standards on the basis of the *WHO Guidelines for Drinking Water Quality* (WHO 2006c).

[17] Other Special Rapporteurs have documented violence and discrimination based on sexual orientation (UNCHR 2001, paras. 48–50; UNGA 2001, paras 17–25).

[18] For example, 'criminalization of homosexual activity . . . would appear to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention' (UNHRCttee 1994, para 8.5).

Similarly, each person should have affordable access to sanitation services, facilities, and installations adequate for the promotion and protection of their human health and dignity. Good health requires the protection of the environment from human waste; this can only be achieved if everyone has access to, and utilizes, adequate sanitation (UNCHR 2004, para. 44).

New tools and techniques

The 'Human rights' section introduced the idea, which is increasingly recognized, that one way of vindicating the right to the highest attainable standard of health is by way of the 'policy approach' i.e. the integration of the right to health in national and international policy-making approaches. For this approach to prosper, the traditional human rights techniques—taking test cases in the courts, 'naming and shaming', letter-writing campaigns, slogans, and so on—will not be sufficient. The 'policy approach' demands the development of new right-to-health skills and tools, such as budgetary analysis, indicators, benchmarks, and impact assessments. In recent years, the health and human rights community has made significant progress towards the development of these new methodologies. Here, by way of illustration, indicators, benchmarks, and impact assessments are briefly introduced in the context of the right to the highest attainable standard of health.

A human rights-based approach to health indicators

The international right to the highest attainable standard of health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a State needs a device to measure this variable dimension of the right to health. The most appropriate device is the combined application of indicators and benchmarks. Thus, a State selects appropriate indicators that will help it monitor different dimensions of the right to health. These indicators might include, for example, maternal mortality ratios and child mortality rates. Most indicators will require disaggregation, such as on the grounds of sex, race, ethnicity, rural/urban, and socioeconomic status. Then the State sets appropriate national targets or benchmarks in relation to each disaggregated indicator.

In this way, indicators and benchmarks fulfil two important functions. *First*, they can help the State to monitor its progress over time, enabling the authorities to recognize when policy adjustments are required. *Second*, they can help to hold the State to account in relation to the discharge of its responsibilities arising from the right to health, although deteriorating indicators do not necessarily mean that the State is in breach of its international right to health obligations (UNCHR 2006, para. 35). Of course, indicators also have other important roles. For example, by highlighting issues such as disaggregation, participation, and accountability, indicators can enhance the effectiveness of policies and programmes.

Health professionals and policy makers constantly use a very large number of health indicators, such as the HIV prevalence rate. Is it possible to simply appropriate these health indicators and call them 'human rights indicators' or 'right to health indicators'? Or do indicators that are to be used for monitoring human rights and the right to health require some special features? If so, what are these special attributes?

The considered view is that some of these health indictors may be used to monitor aspects of the progressive realization of the right to health, provided the following conditions are met (UNGA 2004):

1. They correspond, with some precision, to a right to health norm.
2. They are disaggregated by at least sex, race, ethnicity, rural/urban, and socioeconomic status.
3. They are supplemented by additional indicators—rarely found among classic health indicators—that monitor five essential and inter-related features of the right to health:
   - A national strategy and plan of action that includes the right to health
   - The participation of individuals and groups, especially the most vulnerable and disadvantaged, in relation to the formulation of health policies and programmes
   - Access to health information, as well as confidentiality of personal health data
   - International assistance and cooperation of donors in relation to the enjoyment of the right to health in developing countries
   - Accessible and effective monitoring and accountability mechanisms

In this way, many existing health indicators, such as the maternal mortality ratio and HIV prevalence rate, have an important potential role to play in measuring and monitoring the progressive realization of the right to health, provided that they conform to these conditions.

Impact assessments and the right to the highest attainable standard of health

A further tool that can be employed to monitor the fulfilment of the right to health and hold duty-bearers to account is through impact assessments. They are an aid to equitable, inclusive, robust, and sustainable policy making, and have the objective of informing decision-makers and the people likely to be affected by a new policy, programme, or project so that the proposal can be improved to reduce potential negative effects and increase positive ones. They are one way of ensuring that the right to health—especially of marginalized groups, including the poor—is given due weight in all national and international policy-making processes. From the right to health perspective, an impact assessment methodology is a key feature of a health system and an essential means by which a government can gauge whether or not it is on target to realize progressively the right to health.

At least two distinct methodological approaches are available: To develop a self-standing methodology for human rights impact assessments such as has been done in other fields, such as environmental and social policy; or to integrate human rights into *existing* types of impact assessments. The second approach is consistent with the call on governments to mainstream human rights into all government processes and requires interdisciplinary collaboration (UNGA 2007, para. 39).

In order that an impact assessment uphold rights-based principles, it must: (1) Use an explicit human rights framework, (2) aim for progressive realization of human rights, (3) promote equality and non-discrimination in process and policy, (4) ensure meaningful

participation by all stakeholders, (5) provide information and protect the right to freely express ideas, (6) establish mechanisms to hold the State accountable, and (7) recognize the interdependence of all human rights (Hunt and MacNaughton 2006, p. 32).

If the second approach above is adopted, there are six steps that should be followed to ensure that the right to health is integrated into existing impact assessments: (1) Perform a preliminary check on the proposed policy to determine whether or not a full-scale right-to-health impact assessment is necessary; (2) prepare an assessment plan and distribute information on the policy and the plan to all stakeholders; (3) collect information on potential right-to-health impacts of the proposed policy; (4) prepare a draft report comparing the potential impacts with the State's legal obligations arising from the right to health; (5) distribute the draft report and engage stakeholders in evaluating the options; and (6) prepare the final report detailing the final decision, the rationale for the choices made and a framework for implementation and evaluation.

Overall, the human rights framework for impact assessment adds value because human rights (1) are based on legal obligations to which governments have agreed to abide, (2) apply to all parts of the government encouraging coherence to policy-making and ensuring that policies reinforce each other; (3) require participation in policy making by the people affected, enhancing legitimacy and ownership of policy choices; (4) enhance effectiveness by demanding data disaggregation, participation and transparency; and (5) demand mechanisms through which policy makers can be held accountable.

Conclusion: Key features of a health system from a right to health perspective

The right to the highest attainable standard of health can be understood as a right to an effective and integrated health system, encompassing healthcare and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.

At the heart of this understanding of the right to health is a package of health services, facilities, and goods, extending to healthcare and the underlying determinants of health, such as access to safe water, adequate sanitation, and health-related information. This package must be available, accessible, and of good quality. Also, it must be sensitive to different cultures. While this package will have many features that are common to all countries, there will also be differences between one country and another, reflective of different disease burdens, cultural contexts, resource availability, and so on. This chapter has signalled some elements of this package in relation to neglected diseases, mental disability, sexual and reproductive health, and water and sanitation.

However, besides this essential package of health services, facilities, and goods, a health system must have some additional features if it is to reflect the right to the highest attainable standard of health. These additional features derive from international norms, including CESCR's General Comment 14 on the right to the highest attainable standard of health. While some of these additional features have been described in the preceding paragraphs, they include the following:

1. Formal legal recognition of the right to health in either a national Constitution, or bill of rights, or other statute.
2. An elaboration of what the right to health means, for both the public and private sectors, for example by way of regulations, guidelines and codes of conduct.
3. Research and development for national and local health priorities.
4. A comprehensive situational analysis identifying, inter alia, the health needs of the population, upon which (5) is based.
5. A comprehensive national health plan, including objectives, timeframes, who is responsible for what, reporting procedures, indicators and benchmarks (to measure progressive realization), and a detailed budget.
6. A health financing system that is equitable and evidence-informed.
7. An ex-ante right to health impact assessment methodology that permits the Government to foreshadow the likely impact of a draft law, policy, or programme on the enjoyment of the right to the highest attainable standard of health, thereby enabling it, when necessary, to revise the projected initiative.
8. As much 'bottom up' participation as possible, in relation to policy-making, implementation, and accountability.
9. Access to health-related information and data; data will have to be disaggregated so that the health situation of disadvantaged populations is properly understood, enabling the authorities to devise measures that address health inequities and disadvantage; at the same time, however, arrangements must be in place to ensure that personal medical data remains confidential.
10. As well as effective mechanisms for co-ordination within the health sector, there must also be effective mechanisms for intersectoral coordination in health, because the right to health extends beyond the health sector; moreover, where relevant, there must be effective coordination and referral with traditional health systems.
11. A sufficient number of domestically trained health workers enjoying good terms and conditions of employment; they should be reflective of the country's cultural diversity, including language, and strike a balance between men and women; health workers' training should include human rights.
12. An international dimension, for example, low-income countries should seek international assistance and cooperation in health and high-income countries should provide it.
13. Educational campaigns and other arrangements so that the public knows about its right to health entitlements and how to vindicate them.
14. Effective, transparent, and accessible monitoring and accountability mechanisms, including redress, for both the public and private health sectors.

States have a legal obligation to ensure that their health systems not only include an appropriate package of health services, facilities, and goods, but also the additional features briefly summarized in points 1–14.

Key points

- The right to the highest attainable standard of health is enshrined in several international treaties and numerous national constitutions.
- It gives rise to legally binding obligations on States.

- There is a complementary relationship between public health and the right to the highest attainable standard of health.
- The right to health analytical framework deepens understanding of contemporary public health issues and can help to identify appropriate responses to them.
- The right to the highest attainable standard of health can be understood as a right to an effective and integrated health system, encompassing healthcare and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.

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