

10-9-2013

The Right to Receive and Impart Information as a Cross-Cutting Issue in the Protection of the Right to Health

Carlos Y. Cueto Diaz

Javier Vasquez

Follow this and additional works at: <http://digitalcommons.wcl.american.edu/hlp>

 Part of the [Health Law Commons](#)

Recommended Citation

Diaz, Carlos Y. Cueto, and Javier Vasquez. "The Right to Receive and Impart Information as a Cross-Cutting Issue in the Protection of the Right to Health." *Health Law & Policy Brief* 6, no. 2 (2012): 1-16.

This Article is brought to you for free and open access by Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in *Health Law and Policy Brief* by an authorized administrator of Digital Commons @ American University Washington College of Law. For more information, please contact fbrown@wcl.american.edu.

THE RIGHT TO RECEIVE AND IMPART INFORMATION AS A CROSS-CUTTING ISSUE IN THE PROTECTION OF THE RIGHT TO HEALTH

*Carlos Y. Cueto Diaz and Javier Vásquez**

I. INTRODUCTION TO THE RIGHT TO RECEIVE AND IMPART INFORMATION ON HEALTH

Since its very inception, the United Nations (UN) has shown concern about the effects that withholding information has on individuals and their development as human beings. In 1946, during the first session of the UN General Assembly, the Member States recognized freedom of information as a fundamental human right and the touchstone of all freedoms.¹ This recognition was made formal when, two years later, the UN General Assembly adopted the Universal Declaration of Human Rights (Universal Declaration), consisting of thirty articles that represent the basic rights and freedoms to which all human beings are entitled and which every Member State has undertaken to protect. Among the rights and freedoms listed in the Universal Declaration are (1) the right to receive and impart information; and (2) the right to the enjoyment of the highest attainable standard of health. This paper explores the connection between these rights, and highlights the effect that their nexus has on the well-being of individuals in the context of their

* Carlos Y. Cueto Diaz, a third-year law student at Tulane Law School, has worked on a variety of human rights projects both at home and abroad throughout his career. This article is based on a paper that was presented at the Inaugural Conference on Global Health, Gender, and Human Rights, sponsored by the American University Washington College of Law, Pan American Health Organization, and the Royal Norwegian Embassy in Guatemala. The paper was written in consultation with Sandra Del Pino, PAHO Human Rights Specialist and Marcelo D'Agostino, PAHO Knowledge Management and Communication Manager. Alejandro Morlachetti, PAHO Consultant on Human Rights, reviewed an earlier version of this paper. The opinions expressed in this article are those of the individual authors and do not necessarily represent the position of PAHO, the Royal Norwegian Embassy in Guatemala, the Health Law & Policy Brief, or the American University Washington College of Law.

sexual and reproductive health, gender identities, tobacco use and exposure, disability, ageing, and access to medicines.

II. THE RIGHT TO RECEIVE AND IMPART INFORMATION IN THE UNIVERSAL DECLARATION, THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS, AND THE AMERICAN CONVENTION ON HUMAN RIGHTS

The right to receive and impart information is enshrined in international human rights law. In Article 19 of the Universal Declaration, the UN General Assembly proclaimed that “[e]veryone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.”² In similar words, the International Covenant on Civil and Political Rights (ICCPR), which has the force of international law and is binding on all ratifying States, also protects the right to receive and impart information. In Article 19(2), the State Parties to the ICCPR recognized that “[e]veryone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.”³

The right to receive and impart information has been reaffirmed in regional instruments as well. For example, the Organization of American States (OAS) adopted the American Convention on Human Rights (American Convention), in which it recognized that “[e]veryone has the right to freedom of thought and expression.”⁴ In Article 13 of the American Convention, the OAS explained that this right

encompasses the freedom to convey both information and ideas, regardless of form and medium.⁵

By adopting these documents, the international community effectively placed the right to receive and impart information at the center of international human rights law, and thereby acknowledged, as the UN General Assembly had done in 1946, the role of freedom of information as “an essential factor in any serious effort to promote the peace and progress of the world.”⁶

III. THE RIGHT TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN THE UNIVERSAL DECLARATION, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, AND THE PROTOCOL OF SAN SALVADOR

The right to the enjoyment of the highest attainable standard of health (“right to health”) is also at the center of international human rights law. Article 25(1) of the Universal Declaration proclaimed that “[e]veryone 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 ...”⁷ Similarly, the International Covenant on Economic, Social and Cultural Rights (ICESCR), which also has the force of international law and is binding on all ratifying States, recognized in Article 12(1) “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁸

The right to health has been revalidated at the regional level. Almost twenty years after the adoption of the American Convention, the OAS supplemented its provisions with the passage of the Protocol of San Salvador (“the Protocol”). In Article 10 of the Protocol, the OAS affirmed that “[e]veryone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.”⁹

As I will discuss below, the right to health does not exist in a vacuum. Instead, it must be interpreted to encompass all other related human rights, including, but not limited to, the right to receive and impart information.

IV. CONNECTION BETWEEN THE RIGHT TO RECEIVE AND IMPART INFORMATION AND THE RIGHT TO HEALTH

An intrinsic characteristic of all human rights is that they are interdependent on each other; that is, each human right is indispensable for the exercise and enjoyment of other human rights.¹⁰ The right to health is no exception, and acts in synergy with other human rights such as the right to receive and impart information.¹¹ In other words, a certain degree of physical and mental health is necessary to exercise the right to receive and impart information, at the same time, the protection and exercise of the right to information is essential to achieving a genuine physical and mental well-being.¹² For this reason, a violation or failure to enforce and protect the right to receive and impart information may adversely affect the physical, mental, and social well-being of all people.¹³

More than three decades after the adoption of the ICESCR, the Committee on Economic, Social and Cultural Rights (“the Committee”) endorsed this view in General Comment No. 14, which addressed substantive issues arising in the implementation of Article 12 of the ICESCR. In interpreting the meaning of the provisions of this article, the Committee explained that the right to health is neither the right to be healthy nor the right to health care. Instead, the Committee expressed that the right to health is concerned with the promotion of conditions under which people can lead healthy lives.¹⁴ Whether such conditions exist depends on the confluence of a wide range of socio economic factors, also known as “underlying determinants of health.”¹⁵ These factors include “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and *access to health-related education and information, including on sexual and reproductive health.*”¹⁶ For this reason, the right to health must be interpreted as requiring the creation, promotion, and protection of conditions in the form of facilities, goods, and services that are necessary for the realization of the highest attainable standard of health.”¹⁷

The right to receive and impart information on health is an integral element of the right to health and one of the conditions necessary for its fulfillment. As the Committee unambiguously noted in General Comment No. 14, the right to health is closely related to, and dependent upon, the realization of other human rights such as the rights to education and access to information.¹⁸ With this in mind, the Committee laid out the three types of obligations that the right to health imposes on State parties: the obligations to *respect*, *protect*, and *fulfill*.¹⁹ In particular, a State *respects* the right to health when its national government does not censor, withhold, or intentionally misrepresent health-related information, including sexual education and information.²⁰ Additionally, the government *protects* the right to health by making sure that third parties within its territory do not curtail people's access to health information and services.²¹ Finally, the government *fulfills* the right to health by providing its people with the tools necessary to make informed decisions about their health.²² These tools include "information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services."²³

In other words, the State parties must ensure that individuals are able to exercise, without encumbrances, their "right to seek, receive and impart information and ideas concerning health issues"²⁴ if they are to achieve the highest attainable standard of health. The deliberate withholding or misrepresentation of information vital to health protection or treatment — as well as any other action, policy, or law that contravenes Article 12 — constitutes a violation of the obligations of the State parties under the ICESCR.²⁵

V. ASSESSMENT BY SPECIAL RAPORTEURS OF THE IMPACT OF THE RIGHT TO RECEIVE AND IMPART INFORMATION ON HEALTH

Since the establishment of its mandate in 1993, the Special Rapporteur on freedom of opinion and expression has been concerned with the concept and meaning of the right to information.

In 1995, the Special Rapporteur on freedom of opinion and expression stated that one of the most

essential elements of freedom of speech is the right to seek accessible information.²⁶ According to him, "[f]reedom will be bereft of all effectiveness if the people have no access to information."²⁷ For this reason, he recognized that the long-standing government practice of withholding information from the people must be eradicated.²⁸

Three years later, in 1998, the Special Rapporteur on freedom of opinion and expression moved away from the interpretation of the right to information as an element of freedom of expression, and began to refer to it as a legally enforceable right in and of itself.²⁹ He then added that the right to access to information held by governments "must be the rule rather than the exception."³⁰

In more recent years, the Special Rapporteur on freedom of opinion and expression has embraced the idea that the right to information is necessarily connected to the right to health. In 2002, for example, he highlighted the crucial role that information and education programs play in the fight against HIV/AIDS.³¹ However, he regretted that, while the major players in the fight against HIV/AIDS believe that education and information play an important role in the prevention of the epidemic, a connection has yet to be made between the effectiveness of education and information programs and the effective exercise of the right to freedom of opinion and expression.³²

The failure to appreciate this nexus is worrisome because practice shows that where the right to freedom of opinion and expression is guaranteed and protected, information and education campaigns are more effective.³³ For this reason, the Special Rapporteur on freedom of opinion and expression deemed imperative that communities, associations of people living with HIV/AIDS, teachers, journalists, doctors, self-help groups, among other stakeholders in the fight against HIV/AIDS, be allowed to implement information, education, and other awareness-raising campaigns addressing all HIV/AIDS-related issues.³⁶ In addition to covering these issues, the campaigns must also reach all groups in situation of vulnerability, such as women and young people, men having sex with men, men and women working in prostitution, and intravenous drug users.³⁵ In the context of information that is sensitive or private, such as safe sex or drug use, the means through which that information is conveyed should be

tailored to the target audience taking into consideration its age group, sex, and other relevant factors, including whether the audience is composed of men and women working in prostitution or drug users.³⁶

Along the same line, the Special Rapporteur on the right to the enjoyment of the highest attainable standard of health (“the Special Rapporteur on the right to health”) has emphasized the nexus between access to information and health standards. In 2002, the UN High Commissioner for Human Rights and the Special Rapporteur on the right to health issued a joint statement in which they stated that ensuring access to treatment, care, and support is as important as ensuring access to appropriate information and education.³⁷

In subsequent years, the Special Rapporteur on the right to health consistently stressed that the right to health includes access to information. In 2009, the right to information was directly linked to the concept of informed consent, which was then defined as a “voluntary and *sufficiently informed* decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers[.]”³⁸ This concept “invokes several elements of human rights that are indivisible, interdependent and interrelated.”³⁹ In addition to the right to health, these elements include the right to receive and impart information.

Completeness of information is among the required components of informed consent. In other words, “[i]nformed consent requires disclosure of the associated benefits, risks and alternatives to a medical procedure.”⁴⁰ Without this information, patients are not fully enabled to consent, and no consent so given may be deemed valid.

To guarantee informed consent is to respect the autonomy, self-determination, and human dignity of individuals.⁴¹ As further stressed by the Special Rapporteur on the right to health in 2011, it shall constitute a violation of a patient’s right to health to act, or fail to act, in a way that deprives that patient from the information he or she needs to provide informed consent.⁴² Therefore, the right to receive and impart information on health, as a central component of informed consent, is an integral part

of respecting, protecting, and fulfilling the right to health as elaborated in Article 12 of the ICESCR, and as and enshrined in other international and regional human rights instruments.⁴³

VI. LEGAL LIMITATIONS TO THE RIGHT TO RECEIVE AND IMPART INFORMATION IN THE CONTEXT OF PUBLIC HEALTH

No legal right is an absolute right. The right to freedom of thought and expression, as all other legal rights, may be subject to a series of restrictions. Article 13 of the American Convention establishes the conditions required for restrictions imposed on this right to be considered legitimate:

The exercise of the right [to freedom of thought and expression] shall not be subject to prior censorship but shall be subject to subsequent imposition of liability, which shall be expressly established by law to the extent necessary to ensure: (a) respect for the rights or reputations of others; or (b) the protection of national security, public order, or public health or morals.⁴⁴

Any inquiry into the legitimacy of these limitations shall be done on a case-by-case basis and considering the totality of the circumstances.⁴⁵ The OAS Special Rapporteur for Freedom of Expression has expressed that “the standards for the admissibility of restrictions are applied to all of the constitutive elements of freedom of expression in its diverse manifestations.”⁴⁶ Therefore, limitations imposed upon an individual’s ability to receive and impart information must meet the aforementioned conditions.⁴⁷ Along the same line, the Inter-American Commission on Human Rights (Inter-American Commission) has established the principle that “[e]very person has the right to access ... information about himself or herself,”⁴⁸ and that “[a]ccess to information held by the state is a fundamental right of every individual.”⁴⁹ For this reason, and subject to the limitations set forth in the American Convention, States have no choice but to guarantee the full exercise of this right.⁵⁰

In the landmark case of *Claude-Reyes et al. v. Chile*, the Inter-American Court of Human Rights (Inter-

American Court) also placed the right to receive and impart information on an equal footing with other recognized human rights, including for purposes of the restrictions that apply to it:

[T]he Court finds that, by expressly stipulating the right to ‘seek’ and ‘receive’ ‘information,’ Article 13 of the Convention protects the right of all individuals to request access to State-held information, with the exceptions permitted by the restrictions established in the Convention. Consequently, this article protects the right of the individual to receive such information and the positive obligation of the State to provide it, so that the individual may have access to such information or receive an answer that includes a justification when, for any reason permitted by the Convention, the State is allowed to restrict access to the information in a specific case.⁵¹

In doing so, the Inter American Court reiterated that, pursuant to Article 2 of the American Convention, States must eliminate norms and practices of any type that result in violations of the right to receive and impart information.⁵² In addition, the Inter-American Commission has expressed that States must adopt the necessary measures to protect the right of access to information, especially in the context of health-related issues such as reproduction.⁵³ Ultimately, it is well established that the exercise of the right to receive and impart information on health can only be denied, as stipulated in Article 13 of the American Convention, to protect the rights of others and public order, which includes the issues of national security, public health, and morals.⁵⁴

The Inter-American Commission has stressed that the aforementioned purposes “are the only objectives authorized by the Convention, [and] the limitations must be necessary to achieve imperative public interests that, because of their importance in specific cases, clearly prevail over the social need for the full enjoyment of freedom of expression protected by Article 13.”⁵⁵ In this regard, the Inter-American Court has explained that, when public order is cited as a reason for a limitation, the order defended must not be authoritarian in nature. Instead, “public order” refers to “a democratic

order understood as the existence of the structural conditions that enable all people to exercise their rights in freedom, with neither discrimination nor fear of punishment as a consequence thereof.”⁵⁶ Moreover, any such invocation of “public order” must be based on “real and objectively verifiable causes,” which pose a “certain and credible threat of a potentially serious disturbance of the basic conditions for the functioning of democratic institutions.”⁵⁷ Therefore, States may neither invoke conjectures regarding possible disturbances nor rely on hypothetical circumstances to justify limiting the people’s right to receive and impart information on health.⁵⁸

VII. RELEVANT BARRIERS AND OPPORTUNITIES TO STRENGTHEN AND PROTECT THE RIGHT TO RECEIVE AND IMPART INFORMATION ON HEALTH

The Pan-American Health Organization (PAHO) has identified a series of barriers to improving equity in health, including the assurance of a free and unimpaired exercise of the right to receive and impart information on health. Some of these barriers include, but are not limited to, the lack of expertise in the underlying determinants of health, which include access to health-related information.⁵⁹ Other significant barriers are the generalized ignorance of international human rights provisions, and the limited knowledge in national ministries and secretariats of health, as well as among civil society organizations, about existing obligations and implementation measures in the aforementioned human rights instruments.⁶⁰ Lastly, the limited implementation of national mechanisms to promote and protect the right to health and other related human rights, such as the right to receive and impart information on health, also presents a serious challenge to PAHO’s efforts to improve equity in health,⁶¹ which includes the reduction of morbidity and mortality; the improvement of health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood, and adolescence; the improvement of sexual and reproductive health; and the promotion of active and healthy aging for all individuals.⁶²

The opportunities identified by PAHO to overcome the aforementioned barriers include the continuing support, through technical cooperation with its

Member States, to improve the information systems in sexual and reproductive health, as well as in maternal, neonatal, child, adolescent, and older adult health.⁶³ In addition, PAHO recognizes the importance of strengthening the foundation upon which civil society organizations stand by providing training on health and human rights and supporting the implementation of awareness campaigns, as well as the dissemination of relevant health-related information.⁶⁴ To this end, PAHO adopted a resolution urging its Member States to train health workers on the international human rights instruments dealing with the right to health and other related human rights.⁶⁵ PAHO also recommended that Member States disseminate these instruments among the legislative and judicial branches, as well as among civil society organizations and other relevant social actors.⁶⁶

In addition to PAHO, the Inter-American Commission has recognized a series of barriers to the right to receive and impart information on health. These barriers include, but are not limited to, the equally important right to freedom of conscience. Article 18 of the ICCPR establishes that “[e]veryone shall have the right to freedom of thought, conscience and religion,”⁶⁷ which includes the “freedom ... to manifest his religion or belief in worship, observance, practice and teaching.”⁶⁸ However, Article 18 goes on to stress that freedom of conscience may be subject to limitations arising from the need to protect public safety and order, as well as the health, morals and the fundamental rights and freedoms of others.⁶⁹ The Inter-American Commission has interpreted this provision to mean that, “while healthcare professionals demand respect for their right to conscience, they must also show equal respect for their patients’ rights to conscience.”⁷⁰

The Inter-American Commission recognizes the challenges posed by the fact that health professionals, not unlike their patients, have their own convictions with respect to family planning, emergency oral contraception, sterilization, and abortion.⁷¹ In addition, deeply rooted religious beliefs, personal preferences, or even plain ignorance, may make them take a strong stance against LGBTI persons, persons living with HIV/AIDS, and other persons in situation of vulnerability. To reconcile the conflict

between the health professionals’ right to freedom of conscience and that of the patients they see, the Inter-American Commission suggests that balance be stricken through referrals:

In other words, a health professional may refuse to take care of a patient, but should transfer the patient without objection to another health professional who can provide what the patient is seeking. For example, if a woman needs family planning information and services and/or other lawful reproductive health services, and the health professional has his or her own convictions with respect to the utilization of such services, the professional has the obligation to refer the patient to another health provider who can provide the information and services in question.⁷²

Finally, the European Court of Human Rights (European Court) has also addressed the issue of conscientious objection. In *Pichon and Sajous v. France*, the European Court faced allegations that pharmacists had refused to sell birth control pills because doing so would have been against their religious beliefs.⁷³ In that case, the European Court held that where a health practice or service is legal, health professionals may not allow their religious beliefs to stand as a barrier between their patients and the legal practice or service sought.⁷⁴ In holding so, the European Court reasoned that health professionals remain free to exercise their beliefs in whichever way they choose outside the professional setting.⁷⁵ In the related case of *R.R. v. Poland*, the European Court added that States “are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.”⁷⁶

VIII. FOCUS AREAS

A. Sexual and reproductive health

As seen above, the right to receive and impart information is essential to the attainment of the highest quality of sexual and reproductive health.

Pursuant to Article 12(2)(a) of the ICESCR, States are required to enact “measures to improve child and maternal health, sexual and reproductive health services, including [...] *access to information*, as well as to resources necessary to act on that information.”⁷⁷

The Special Rapporteur on the right to health has also linked information and health in the context of sexual and reproductive health issues. In 2004, he reminded States of their obligations in the areas of reproductive health and maternal and child health services.⁷⁸ Particularly, States should be committed to providing and improving a wide range of sexual and reproductive health services, such as “access to family planning, pre- and post-natal care, emergency obstetric services, and *access to information*.”⁷⁹ Furthermore, he interpreted the prohibition against discrimination to include the duty to ensure that health information and services are made available to groups in situation of vulnerability.⁸⁰

The Special Rapporteur on the right to health also underscored in that year’s report the need to empower women to make decisions that affect their sexual and reproductive health⁸¹ — an empowerment which necessarily depends on the unimpaired access to sexual and reproductive health information. For example, he pointed out that unsafe abortions kill approximately 68,000 women each year.⁸² To prevent this, he advised that “women with unwanted pregnancies *should be offered reliable information* ... , including information on where and when a pregnancy may be terminated legally.”⁸³

Interestingly, States can achieve significant improvements in this context even when resources are scarce.⁸⁴ An example of this is the case of Sri Lanka, where important advances have been made over the last decades in relation to sexual and reproductive health by improving education and increasing female literacy, among other measures.⁸⁵ In addition, the repeal of laws such as those that criminalize abortion is not tied to resource constraints.⁸⁶ Therefore, a simple cost-benefit analysis would seem to indicate that such laws must be immediately removed to facilitate women’s access to information and to ensure the full enjoyment of their right to health.⁸⁷

In 2006, the Special Rapporteur on the right to health highlighted again the nexus between information and health by stressing that the right to health entitles women to information on sexual and reproductive health.”⁸⁸ In that year’s report, he approvingly noted the “three delays” model, which suggests that maternal mortality is due to delays in: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate facility; and (3) receiving adequate care when a facility is reached.⁸⁹ According to him, poor education and lack of access to information contribute negatively to the first delay.⁹⁰ To the extent that women lack the tools necessary to identify an emergency and to make an informed and reasoned decision as to where to seek services, they unavoidably become exposed to a greater risk of maternal mortality.

B. Gender identities

The guiding principle of non-discrimination in international human rights law stands for the idea that individuals must be able to enjoy the full spectrum of human rights without distinction on the basis of certain enumerated grounds, including, but not limited to, sex. In General Comment No. 14, the Committee on Economic, Social and Cultural Rights (“the Committee”) explained that the prohibition against discrimination on the basis of sex also precludes States from discriminating against individuals in access to health care and underlying determinants of health, such as the right to receive and impart information, on the basis of sexual orientation and gender identity.⁹¹

Echoing the Committee’s opinion, the Human Rights Committee (CCPR) held in *Toonen v. Australia* that a distinction between individuals on the basis of sexual orientation and gender identity amounted to a violation of Article 2 of the ICCPR.⁹² In that case, the CCPR faced allegations that Tasmania engaged in “a campaign of official and unofficial hatred” against LGBTI persons. In its opinion, the CCPR noted that this campaign has *made it difficult for the Tasmanian Gay Law Reform Group to disseminate information about its activities* and advocate the decriminalization of homosexuality.”⁹³ The CCPR ultimately rejected the Tasmanian government’s argument that its laws criminalizing homosexuality were justified on public health grounds as part of

their effort to combat the spread of HIV/AIDS.⁹⁴ The CCPR held that “the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS.”⁹⁵ In doing so, the CCPR observed that “statutes criminalizing homosexual activity tend to impede public health programmes by driving underground many of the people at the risk of infection.”⁹⁶ Therefore, the CCPR emphasized that the “criminalization of homosexual activity ... would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.”⁹⁷

Despite the *Toonen* decision, many countries continue to criminalize homosexual behavior. In his report to the Human Rights Council (HRC), the Special Rapporteur on the right to health noted that there were, as of 2010, eighty countries in which consensual same-sex conduct is punishable by law, and that many countries also penalized individuals merely because of their sexual orientation and gender identity.⁹⁸ He then warned that these laws have the effect of substantially diminishing the self-worth and dignity of individuals, and thus prevent the realization of the right to health, as outlined in Article 12 of the ICESCR, and other related human rights.⁹⁹ Among these related human rights is the right to seek and receive information on health.

A natural consequence of criminalization is the perpetuation of existing prejudices and stereotypes, which prevent otherwise-able institutions from properly addressing the concerns of LGBTI persons.¹⁰⁰ For example, the Diagnostic and Statistical Manual of Mental Disorders (“the Manual”), which is published by the American Psychiatric Association and standardizes the criteria for the classification of mental disorders, retained homosexuality as a mental disorder until very recently.¹⁰¹ However, other so-called “gender identity disorders” are still included in the Manual.¹⁰² This is the case, for example, of transvestic fetishism.¹⁰³ According to the Manual, transvestites should be treated with psychotherapy aimed at uncovering and working through the underlying causes of their behavior, without regard to the possible discomfort that they may feel because of their gender identity.¹⁰⁴ Such attempts to cure are inappropriate, cause significant

psychological distress, and, based on a well-founded fear of prosecution, make it less likely that LGBTI persons seek health-related information.¹⁰⁵

C. Tobacco consumption and exposure to tobacco smoke

Tobacco has also been at the center of this discussion. In 2003, the World Health Assembly adopted the Framework Convention on Tobacco Control (FCTC) as a response to the rapid increase of tobacco consumption throughout the world. In Article 3, the FCTC states that its objective is “to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke”¹⁰⁶ To achieve this objective, the Parties to the FCTC must ensure that information regarding the consequences of tobacco consumption and exposure are widely available.¹⁰⁷ To this end, Article 10 mandates the Parties to adopt and implement effective measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities and the general public information about the contents and emissions of tobacco products.¹⁰⁸

Article 12 further develops the duty of public disclosure by elaborating on the requirements of education, communication, and training: the three pillars of public awareness.¹⁰⁹ More specifically, the Parties are required to carry out programs on the health risks of tobacco, the benefits of a tobacco-free lifestyle, and the environmental consequences of tobacco production and consumption to educate, communicate with, and train the public.¹¹⁰ For purposes of the FCTC, “**education** comprises a continuum of teaching and learning about tobacco which empowers people to make voluntary decisions, modify their behavior and change social conditions in ways that enhance health.”¹¹¹ Along the same line, “**communication** is essential to change attitudes about tobacco production, manufacture, marketing, consumption and exposure to tobacco smoke, discourage tobacco use, curb smoking initiation, and encourage cessation, as well as being necessary for effective community mobilization towards providing enabling environments and achieving sustainable social change.”¹¹² Finally, “**training** describes the

process of building and sustaining the necessary capacity for a comprehensive tobacco-control programme through attaining vocational or practical skills and knowledge that relate to specific core competencies.”¹¹³

Education, communication, and training are the means of raising public awareness regarding the adverse effects of tobacco consumption and exposure to tobacco smoke.¹¹⁴ As a working group for the FCTC has advised, the right to health requires that social norms provide enabling environments in which people can lead a tobacco-free lifestyle.¹¹⁵ This creates a duty to educate, communicate with, and train people to ensure a high level of public awareness of tobacco control, the harms of tobacco production, consumption and exposure to tobacco smoke, and the strategies and practices of the tobacco industry to undermine tobacco control efforts.¹¹⁶

D. Disability

The UN adopted the Convention on the Rights of Persons with Disabilities (“the Convention”) in 2006 to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.¹¹⁷ To achieve this objective, the Parties to the Convention must ensure that persons with disabilities have the information they need regarding mobility aids and devices, assistive technologies, and other forms of assistance, support services, and facilities.¹¹⁸ This obligation goes to the core of the concept of accessibility, which, as outlined in Article 9 of the Convention, requires Parties to enable persons with disabilities to lead a fully independent and participative life.¹¹⁹

Accessibility, as described above, is strictly connected to the freedoms of expression, opinion, and access to information. More specifically, Parties must ensure that persons with disabilities are able to exercise the right to freedom of expression and opinion, which includes “the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice.”¹²⁰ These measures should include a guarantee that persons with disabilities have access to information intended for the general public in

accessible formats and appropriate technologies, in a timely manner, and at no additional cost.¹²¹ In addition, Parties must facilitate the use of the appropriate means, modes, and formats of communication in official interactions with the government, including sign languages, Braille, and augmentative and alternative communication.¹²²

E. Ageing

The Second World Assembly on Ageing adopted the Madrid International Plan of Action on Ageing (“the Madrid Plan”) in 2002. The objective of the Madrid Plan is “to respond to the opportunities and challenges of population ageing in the twenty-first century and to promote the development of a society for all ages.”¹²³ One of the major challenges identified by the Madrid Plan relates to the human rights of older persons: “The promotion and protection of all human rights and fundamental freedoms ... is essential for the creation of an inclusive society for all ages in which older persons participate fully and without discrimination and on the basis of equality.”¹²⁴

The right to receive and impart information on health is at the center of the Madrid Plan. This document suggests that policymakers “[p]rovide information and access to facilitate the participation of older persons in mutual self-help, intergenerational community groups and opportunities for realizing their full potential.”¹²⁵ In addition, policymakers should implement information campaigns that address older persons on topics such as unhealthy diet, physical inactivity, and other unhealthy behaviors.¹²⁶ Other topics may include, for example, the symptoms, treatment, consequences, and prognosis of mental diseases, as well as the prevention and management of disabilities.¹²⁷

Soon after the passage of the Madrid Plan, the UN General Assembly endorsed its suggestions and reaffirmed the commitment of the international community to safeguard the security and dignity of persons as they age, ensuring that they continue to participate in their societies as citizens with full rights.¹²⁸ More recently, the UN General Assembly recognized the need for ensuring that older persons have access to information about their rights to enable them to fully and justly participate in society.¹²⁹

The OAS has also pledged to protect the rights of older persons. Last year, for example, the OAS urged its Member States to take action to make older persons, their families, and caregivers aware of their rights and responsibilities.¹³⁰ Such information awareness campaigns would, in turn, contribute “to uphold the dignity and safeguard the physical, mental and social well being of older persons.”¹³¹

F. Access to medicines

The international obligation of States with regards to medicines is comprised of four different elements; that is, States must ensure that medicines are (1) available, (2) accessible, (3) culturally acceptable, and (4) of good quality.¹³²

One of the dimensions of the requirement of availability deals with the issue of access to information. More specifically, “reliable information about medicines must be accessible to patients and health professionals so they can take well-informed decisions and use medicines safely.”¹³³ This requirement is directly connected to the issue of informed consent, as explained above, and requires that accurate and appropriate information about medicines is made available to health professionals and the general public alike.¹³⁴

In addition to being essential to informed consent, the unimpaired access to information about medicines is paramount in the fight against corruption. According to the Special Rapporteur on the right to health, corruption is endemic in some medicine supply systems.¹³⁵ For example, “[p]roducts are diverted; unofficial ‘fees’ are required for customs clearance; counterfeit medicines are permitted to circulate and so on.”¹³⁶ To protect these systems, States must ensure that health professionals, patients and their families, and the general public are able to freely exercise their right to receive and impart information about medicines.¹³⁷ By doing so, States will help to create a more transparent environment, which could eventually lead to the elimination of corruption in health systems and, in particular, in medicine supply systems.¹³⁸

IX. CONCLUSIONS

Every UN Member State has undertaken various international legal obligations with respect to

human rights. These obligations include, but are not limited to, the duty to ensure that their citizens are able to freely and fully exercise their right to the highest attainable standard of health. This right to health, as it is commonly known, is intrinsically connected to other human rights, including the right to information. Because the ability of an individual to access information regarding his/her health is a determinant factor in his/her well-being, the rights to health and information must be seen as dependant on each other. In particular, individuals have a right to receive and impart information on health. Their ability or inability to exercise such a right will directly affect their well-being.

As seen in the focus areas above, the right to receive and impart information on health plays an important role in the ability of individuals, especially women, to receive adequate sexual and reproductive health services. For example, their access to information regarding family planning, pre- and post-natal care, emergency obstetric services may be impaired by governmental policy or for religious reasons, or for both. This is particularly worrisome in the context of access to contraceptive measures and abortion, which face direct opposition from secular governments and private groups.

The right to receive and impart information on health needs special protection in the context of gender identities. As seen above, many countries continue to criminalize consensual same-sex conduct, which drives individuals underground and away from the reach of public health policies, plans, and programs. This is achieved by passing laws that directly prohibit any sort of homosexual activity, including, but not limited to, the dissemination of information of interest to LGBTI persons. As the Human Rights Committee held, no such policy may be justified on public health grounds. Instead, such policies are proven to run counter to the implementation of effective education programs on disease prevention and other public health priorities.

The tobacco industry, in its effort to disseminate the consumption of tobacco products, has also tried to diminish the right of individuals to receive and impart information. States, in turn, must respond by engaging in education, communication, and training efforts to raise public awareness regarding

the adverse effects of tobacco consumption and exposure to tobacco smoke. The dissemination of information in this context may lead to the shaping of social norms and attitudes toward tobacco, and to the eventual creation of environments which are conducive to the full achievement of the highest standard of health in all populations.

The right to receive and impart information on health is also linked to the issues of disability and ageing. To promote, protect, and ensure the full and equal enjoyment of all human rights of persons with disability and older persons, these individuals must be able to access information that is relevant to their needs. In the case of persons with disabilities, for example, States have the duty to provide information regarding appropriate forms of assistance and support on an equal basis with others and through all forms of communication of their choice. Alternatively, older persons must be able to access information on health-related topics, such as adequate diets and physical exercises, so as facilitate their participation in mutual self-help, intergenerational community groups, and opportunities for realizing their full potential.

In regard to access to medicines, States must not only ensure that medicines are available, accessible, culturally acceptable, and of good quality; in addition, they must ensure that reliable information about medicines is accessible to health professionals and patients. By doing so, health professionals will be better able to provide transparent services to their patients, who in turn will be better equipped to give health professionals their consent to a treatment or procedure. Finally, the unimpaired dissemination of information will undoubtedly create a more informed consumer base, which is an essential tool in the worldwide fight against corruption in medicine supply systems.

For the reasons outlined above, States should take immediate and improved action to remove the barriers and exploit the opportunities of the right to receive and impart information. Some of these barriers may relate to ignorance of international and regional human rights and instruments, or to the refusal by health professionals to offer services on the basis of their religious or personal beliefs. In either case, the removal of the barrier is not tied to significant financial considerations. Opportunities for removal

are grounded, for example, on educational campaigns and training sessions that educate all relevant actors on the relationship between human rights and health. In addition, the issue of conscientious objection could be easily addressed through the use of referrals so as to permit the unimpaired flow of health-related services and information.

Not only would the relative cost of these remedial actions be minimal to the individual States (especially in light of PAHO's cooperation), but the benefits of such actions would be enjoyed by the full range of their populations: men and women, including children and older persons; whether heterosexual or members of the LGBTI community; smokers or non-smokers; healthy, sick or disabled.

¹ Calling of an International Conference on Freedom of Information, ¶ 1, U.N. GAOR, 1st Sess., U.N. Doc. A/RES/59(I) (Dec. 14, 1946) [hereinafter *Calling of an International Conference on Freedom of Information*]

² Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.S. Doc. A/RES/217(III) (Dec. 10, 1948) [hereinafter *Universal Declaration of Human Rights*].

³ International Covenant on Civil and Political Rights, G.A. Res. 2200 A, U.S. Doc. A/RES/21/2200 (Dec. 16, 1966) [hereinafter *International Covenant on Civil and Political Rights*].

⁴ *American Convention on Human Rights*, art. 13, Adopted at the Inter-American Specialized Conference on Human Rights, San Jose, Costa Rica, Nov. 22, 1969, <http://www.cidh.oas.org/Basicos/English/Basic3.American%20Convention.htm> [hereinafter *American Convention on Human Rights*] (last visited Nov. 3, 2012).

⁵ *Id.*

⁶ *Calling of an International Conference on Freedom of Information*, *supra* note 1, ¶ 2.

⁷ Universal Declaration of Human Rights, *supra* note 2, art. 25.

⁸ International Covenant on Civil and Political Rights, *supra* note 3, art. 12.

⁹ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), art. 10, Nov. 16, 1999, O.A.S.T.S. No. 69, 28 I.L.M. 1641.

¹⁰ Pan American Health Organization, 50th Directing Council, 62nd Session of the Regional Committee. Doc. CD50/12, *Health and Human Rights*, ¶ 8 (Aug. 31, 2010).

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* ¶ 9.

¹⁴ UN Comm. on Econ., Soc. and Cultural Rights, The Right to the Highest Attainable Standard of Health: General Comment No. 14, ¶ 4, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment 14*].

¹⁵ *Id.* ¶ 11.

¹⁶ *Id.* (emphasis added).

¹⁷ *Id.* ¶ 9.

¹⁸ General Comment 14, *supra* note 14, ¶ 11.
¹⁹ *Id.* ¶ 33.
²⁰ *Id.* ¶ 34.
²¹ *Id.* ¶ 35.
²² *Id.* ¶ 37.
²³ *Id.*
²⁴ IGeneral Comment 14, *supra* note 14, ¶ 12(b).
²⁵ *See id.* ¶ 50.
²⁶ Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, *Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*, ¶ 34, Econ. and Soc. Council, U.N. Doc. E/CN.4/1995/32 (Dec. 14, 1994) (by Abid Hussain) [hereinafter *1994 Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*].
²⁷ *Id.*
²⁸ *Id.*
²⁹ Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, *Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*, ¶ 11, Econ. and Soc. Council, U.N. Doc. E/CN.4/1998/40 (Jan. 28, 1998) (by Abid Hussain) [hereinafter *1998 Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*].
³⁰ *Id.* ¶ 12.
³¹ Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, *Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*, ¶ 41, Econ. and Soc. Council, U.N. Doc. E/CN.4/2003/67 (Dec. 30, 2002) (by Ambeyi Ligabo) [hereinafter *2002 Rep. on the Promotion and Protection of the Right to Freedom of Opinion and Expression*].
³² *Id.* ¶ 51.
³³ *Id.* ¶ 52.
³⁴ *Id.*
³⁵ *Id.*
³⁶ *Id.*
³⁷ Press Release, Joint Statement by Sergio Vieira De Mello, UN High Commissioner for Human Rights, and Paul Hunt, U.N. Special Rapporteur on the Right to Health on World AIDS Day, ¶ 4. (Nov. 29, 2002).
³⁸ U.N. Secretary-General, *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 9, U.N. Doc. A/64/272 (Aug. 10, 2009) (by Anand Grover) (emphasis added).
³⁹ *Id.* ¶ 19.
⁴⁰ *Id.* ¶ 15.
⁴¹ *Id.* ¶ 18.
⁴² U.N. Secretary-General, *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 37, U.N. Doc. A/65/255 (Aug. 6, 2010) (by Anand Grover).
⁴³ International Covenant on Civil and Political Rights, *supra* note 3, art. 12.
⁴⁴ *American Convention on Human Rights*, *supra* note 4, art. 13.
⁴⁵ *Ivcher-Bronstein v. Peru*. Merits, Reparations and Costs, Inter-Am. Ct. H.R. (ser. C) No. 74, ¶ 51 (Feb. 6, 2001).
⁴⁶ Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, *Rep. of*

the Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, ¶ 63, Econ. and Soc. Council, U.N. Doc. OEA/Ser.L/V/II, CIDH/RELE/INF. 2/09, (Dec. 30, 2009) [hereinafter *Rep. of the Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression*].
⁴⁷ *Id.*
⁴⁸ Inter-American Commission on Human Rights, *Declaration of Principles on Freedom of Expression*, ¶ 3, 108th Reg. Sess., (Oct. 19, 2000).
⁴⁹ *Id.* ¶ 4.
⁵⁰ *Id.*
⁵¹ *Claude-Reyes et al. v. Chile*. Merits, Reparations and Costs, Inter-Am. Ct. H.R. (ser. C) No. 151 ¶ 77 (Sept. 19, 2006).
⁵² *Id.* ¶ 163.
⁵³ Inter-American Commission on Human Rights, *Access to information on reproductive health from a human rights perspective*, ¶ 39, OEA/Ser.L/V/II., Doc. 61 (Nov. 22, 2011) [hereinafter *Access to Information on Reproductive Health from a Human Rights Perspective*].
⁵⁴ *Id.* ¶ 23.
⁵⁵ *Rep. of the Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression*, *supra* note 45, ¶ 74.
⁵⁶ *Id.* ¶ 58.
⁵⁷ *Id.* ¶ 82.
⁵⁸ *Id.*
⁵⁹ Pan American Health Organization, Official Document No. 328, *Proposed Strategic Plan 2008-2012*, 69 October 2007 (adopted by the 27th Pan American Sanitary Conference, 59th Session of the Regional Committee, Oct. 5 2007. *See* Resolution CSP27.R4.)
⁶⁰ Pan American Health Organization, *Health and Human Rights Concept Paper* ¶ 14, 50th Directing Council, (62nd Sess. of the Reg. Committee, Document CD50/12) (Aug. 31, 2010).
⁶¹ *Id.*
⁶² Pan American Health Organization, *Health and Human Rights Concept Paper* Annex E, 2, 50th Directing Council (62nd Session of the Reg. Committee, Document CD50/12) (Aug. 31, 2010).
⁶³ *Id.* at Annex E, 3.
⁶⁴ *Id.* ¶ 21(e).
⁶⁵ Pan American Health Organization, *Health and Human Rights* 3, 50th Directing Council (62nd Sess. of the Reg. Committee, 6th Plenary Meeting, Resolution CD50.R8) (Sept. 29, 2010).
⁶⁶ *Id.*
⁶⁷ International Covenant on Civil and Political Rights, *supra* note 3, art. 18.
⁶⁸ *Id.*
⁶⁹ *Id.*
⁷⁰ *Access to Information on Reproductive Health from a Human Rights Perspective*, *supra* note 52, ¶ 94.
⁷¹ *Id.* ¶ 95.
⁷² *Id.*
⁷³ *Pichon and Sajous v. France*, App. No. 49853/99, 2001-X Eur. Ct. H.R., ¶ 9.
⁷⁴ *Id.* ¶ 14.
⁷⁵ *Id.*

- ⁷⁶ R.R. v. Poland, App. No. 27617/04, Reports of Judgments and Decisions 2011 Eur. Ct. H.R., ¶ 206.
- ⁷⁷ General Comment 14, *supra* note 14, ¶ 14 (emphasis added).
- ⁷⁸ Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Econ. and Soc. Council, ¶ 29, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004) (by Paul Hunt) [hereinafter *2004 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*].
- ⁷⁹ *Id.* (emphasis added).
- ⁸⁰ *Id.* ¶ 39.
- ⁸¹ *Id.*
- ⁸² *Id.* ¶ 11.
- ⁸³ 2004 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 77, ¶ 30 (emphasis added).
- ⁸⁴ *Id.* ¶ 31.
- ⁸⁵ *Id.*
- ⁸⁶ Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 20, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover) [hereinafter *2011 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*].
- ⁸⁷ *Id.*
- ⁸⁸ Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 13, U.N. Doc. A/61/338 (Sept. 13, 2006) (by Paul Hunt) [hereinafter *2006 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*].
- ⁸⁹ *Id.* ¶ 21.
- ⁹⁰ *Id.*
- ⁹¹ Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 9, U.N. Doc., A/HRC/14/20 (Apr. 27, 2010) [hereinafter *2010 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*].
- ⁹² Human Rights Committee, *Toonen v. Australia*, CCPR/C/50/D/488/1992, ¶ 11 (Apr. 4, 1994) [hereinafter *Toonen v. Australia*].
- ⁹³ *Id.* ¶ 2.6 (emphasis added).
- ⁹⁴ *Id.* ¶ 8.4.
- ⁹⁵ *Id.* ¶ 8.5.
- ⁹⁶ *Id.*
- ⁹⁷ *Id.*
- ⁹⁸ 2010 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 90, ¶¶ 8, 15.
- ⁹⁹ *Id.* ¶ 7.
- ¹⁰⁰ *Id.* ¶¶ 17-18.
- ¹⁰¹ *Id.* ¶ 22.
- ¹⁰² *Id.* fn. 36.
- ¹⁰³ *Psychiatric Disorders, Paraphilias and Sexual Disorders, Transvestic Fetishism*, ALLPSYCH ONLINE <http://allpsych.com/disorders/paraphilias/transvestite.html> (last visited Feb. 20, 2012).
- ¹⁰⁴ *Id.*
- ¹⁰⁵ 2010 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 96, ¶ 23.
- ¹⁰⁶ World Health Organization, 56th World Health Assembly, WHA56.1, *WHO Framework Convention on Tobacco Control*, art. 3 (May 21, 2003).
- ¹⁰⁷ *Id.* art. 4.
- ¹⁰⁸ *Id.* art. 10.
- ¹⁰⁹ World Health Organization, Conference of the Parties to the WHO Framework Convention on Tobacco Control, *Guidelines for Implementation of Article 12 of the WHO Framework Convention on Tobacco Control*, plen. mtg., 4th Sess., ¶ 4, FCTC/COP4(7) (Nov. 19, 2010) [hereinafter *Guidelines for Implementation of Article 12 of the WHO Framework Convention on Tobacco Control*].
- ¹¹⁰ See *id.*
- ¹¹¹ *Id.* ¶ 20 (emphasis in original).
- ¹¹² *Id.* ¶ 21 (emphasis in original).
- ¹¹³ *Id.* ¶ 22 (emphasis in original).
- ¹¹⁴ *Guidelines for Implementation of Article 12 of the WHO Framework Convention on Tobacco Control*, *supra* note 114, ¶¶ 1, 3(i), 3(v), 4, 7, 18, 19, 80(a).
- ¹¹⁵ *Id.* ¶ 19.
- ¹¹⁶ *Id.* ¶ 3(i).
- ¹¹⁷ U.N. GAOR, 61st Sess., 76th plen. mtg., U.N. Doc. A/61/611, *Convention on the Rights of Persons with Disabilities*, art. 1 (Dec. 6, 2006) [hereinafter *Convention on the Rights of Persons with Disabilities*].
- ¹¹⁸ *Id.* art. 4.
- ¹¹⁹ *Id.* art. 9.
- ¹²⁰ *Id.* art. 21.
- ¹²¹ *Id.*
- ¹²² *Id.*
- ¹²³ UN General Assembly, Second World Assembly on Ageing, 10th plen. mtg., U.N. Doc. A/CONF.197/9, *Political Declaration*, art. 1 (Apr. 12, 2002).
- ¹²⁴ UN General Assembly, Second World Assembly on Ageing, 10th plen. mtg., U.N. Doc. A/CONF.197/9, *Madrid International Plan of Action on Ageing*, ¶ 13 (Apr. 12, 2002).
- ¹²⁵ *Id.* ¶ 21(d).
- ¹²⁶ *Id.* ¶ 66(e).
- ¹²⁷ *Id.* ¶ 86(h).
- ¹²⁸ UN General Assembly, 57th Sess., 77th plen. mtg., U.N. Doc. A/RES/57/167, *Follow-up to the Second World Assembly on Ageing*, ¶ 6 (Jan. 16, 2003).
- ¹²⁹ UN General Assembly, 65th Sess., 71st plen. mtg., U.N. Doc. A/RES/65/182, *Follow-up to the Second World Assembly on Ageing*, ¶ 14 (Feb. 4, 2011).
- ¹³⁰ OAS General Assembly, 41st Regular Sess., 4th plen. sess., U.N. Doc. AG/RES. 2654 (XLI-O/11), *Protecting the Human Rights of Older Persons*, ¶ 3 (June 7, 2011).
- ¹³¹ *Id.*

¹³² 2006 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 87, ¶¶ 47-51.

¹³³ *Id.* ¶ 49.

¹³⁴ *Id.* ¶¶ 49-50.

¹³⁵ *Id.* ¶ 78.

¹³⁶ *Id.*

¹³⁷ See 2006 Rep. on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 87, ¶ 80.

¹³⁸ *Id.*

ANNEX: WORKING GROUP RECOMMENDATIONS

Listed below are recommendations that will serve to advance the use of international human rights instruments and standards as tools to review and reform health policies, plans, programs and laws.

These recommendations have been suggested by the working groups that convened on March 21 and 22, 2012 at the Inaugural Conference on Global Health, Gender and Human Rights, which was organized by the American University Washington College of Law and PAHO/WHO. The recommendations were recorded by the working group secretaries and reviewed and edited by Alejandro Morlachetti and Javier Vazquez of PAHO. These recommendations do not necessarily reflect the views of the author(s) of the preceding article.

The working groups that have issued recommendations about the right to receive and impart information on health were divided according to the following topics:

Group 1: Tobacco control

- Labeling and pictures on tobacco boxes should comply with Article 11 of the WHO Framework Convention on Tobacco Control, a tool to protect the right to life and to personal integrity of smokers and non-smokers;
- Implementation of effective measures for public disclosure of information about the toxic constituents of tobacco products and the emissions they may produce;
- Campaigns focused on women/girls;
- Dissemination of correct information on the consequences of smoking;
- Disclosure of ingredients;
- Right to provide information on cessation products and access to them.

Group 2: Access to medicines

- Dissemination of appropriate information to the Ministries of Health with the support of PAHO, the UN Special Rapporteur, and the academia;
- Information about the protection of the right to life and the right to personal integrity while facilitating the access to goods, products and technologies;
- Need to involve private actors and pharmaceutical companies, along with civil society, professional groups, universities, etc., in the implementation of treaties.

Group 3: Older persons

- The right to freedom of expression should be applied in the context of the health information that older persons need to decide whether to provide consent before treatment;
- Provide accurate information regarding the right to palliative care and the right to die with dignity.

Group 4: Gender identities

- Dissemination of information to fight stigmatization and misinformation about the concept and meaning of gender identities;
- Emphasize that accurate information is crucial to prevent and abolish criminalization of certain conducts and practices related to sex;
- Provide appropriate information on human rights to high level officials with the support of American University legal clinics, PAHO, and the relevant networks, including Redlactrans, to achieve the decriminalization of certain sex conducts.

Group 5: Maternal mortality

- Dissemination of pertinent information on scientific evidence of the non-abortive characteristic of emergency contraception to judges, parliamentarians, and public health personnel;
- Dissemination of relevant information to women, girls, and adolescents in situation of vulnerability, such as those that are deprived of liberty in prisons, juvenile centers, psychiatric hospitals, etc.

Group 6: Disabilities

- Emphasize that access to appropriate information is key with regard to legal capacity as defined in the UN Convention on the Rights of People with Disabilities (CRPD);

- Provide information to people with disabilities, families, parents, and associations about their rights;
- Provide information via materials and training to guardians and judges to avoid practices and decisions that unnecessarily restrict the capacity of persons living with disabilities to exercise civil, political, economic, social, and cultural rights in violation of the CRPD;
- Dissemination of information about the obligations that Governments have accepted when ratifying the CRPD, including the recommendations of the Committee on the Rights of Persons with Disabilities.