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When the Right to Health and the Right to Religion Conflict: A Human Rights Analysis

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WHEN THE RIGHT TO HEALTH AND THE RIGHT TO RELIGION CONFLICT: A HUMAN RIGHTS ANALYSIS

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Health and religion are both important to the world community. The right to each is enshrined in international law, yet the legal relationship between the rights remains largely unexplored. Often, the right to religion and the right to health support each other. Religious beliefs and practices, however, sometimes conflict with measures that are necessary for the protection and promotion of public health.[1] In these cases, where public health is significantly affected, we argue that governments should base law and policy on scientifically proven measures. While such measures may curtail the right of citizens to engage in certain religiously based practices, narrowly-tailored restrictions are compatible with international law.

Religion and health are interrelated in ways that can result in both positive and negative health outcomes. For many people, religion has a strong influence on the choices and decisions they make as it shapes and informs their understanding of the universe. Religion also informs culture and custom, which themselves directly impact health. Religious practices are often consistent with public health. For example, most religions emphasize monogamy and faithfulness to one's partner, practices that reduce the spread of sexually transmitted infections. However, religious belief and practice may also conflict with health protection and promotion. People die from diseases that could have been cured by relatively simple medical interventions because of religious beliefs that such interventions thwart the will of God. Religiously required ceremonies can be dangerous to the physical health of

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1. Public health has been defined as "what we, as a society, do collectively to assure the conditions for people to be healthy." LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW AND ETHICS: A READER xix (2002) (citing Institute of Medicine, *The Future of Public Health*, Washington, D.C., National Academy Press (1988)). Public health focuses on population health and community interventions rather than individual health interventions. *See id.*, at 11-14.

participants. Religious mores may impede the distribution of information about sexually transmitted infections and their prevention. The impact of religion on health can be both overt and subtle and is important to consider when analyzing points of conflict between religion and health.

Health is a fundamental necessity, a minimal level of which is required to enjoy many aspects of life, including religious practice. The right to health has been codified in multiple national and international legal instruments, and is now widely considered to apply to both physical and mental health. The prevailing codification, to which some 150 countries are legally bound, characterizes the right to health as encompassing a right to "the highest attainable standard" of health.

Similarly, the dominance of religion in people's lives has led to its recognition as a fundamental human right. The right to religion has been defined as protection of "freedom of thought, conscience, and religion;" it encompasses the adoption of a religion or belief as well as the public and private practice of the religion. Notably, the right to religion, as it has developed in international law, is limited. The international community has recognized that the right to religion may have to be restricted in order to further other common societal goals, including public health.

When a government is faced with a choice between a policy grounded in religion and a policy based on a conflicting, but scientifically-proven, health intervention, basing policy on science in order to protect and promote health is consistent with international law, even if it means curtailing the right of citizens to practice their religious beliefs. Three concepts support this conclusion.

First, the right to religion is limited under international law, which expressly permits the restriction of the practice of religion for the furtherance of public health. Second, the right to health is not similarly limited under international law. Finally, policies based on religion that negatively affect health may also undermine other international human rights.

The international community has recognized that the right to religion may have to be restricted in order to further other common societal goals, including public health. Provision for such limitations was made in the documents that enshrine the right to religion. The ability of a government to restrict the right to practice one's religion is not unlimited, however. Such restrictions must follow certain strict guidelines

designed to prevent overly broad or discriminatory application. Further, it is only the practice of religion that may be limited; there are no instances in which a government is entitled to restrict religious belief.

In contrast to the limitations on the right to religion enumerated in international law, there are no parallel limitations placed on the right to health. Applying the rules of treaty interpretation, the absence of parallel limiting language with regard to the right to health connotes a lack of intention on the part of the drafters to limit the right.

In addition, basing policies that affect health on religion may thwart the realization of other internationally recognized human rights. For example, if religiously motivated notions of propriety keep important public health interventions from being discussed in a society, then the public could be denied the right to the benefits of science as well as the right to education. When policy is made based on majority religious viewpoints at the expense of countervailing beliefs, conventions requiring non-discrimination and equal treatment may also be violated.

It should be emphasized that in the absence of a conflict between religion and science-based health interventions, there is no need or justification to restrict religious practice for health purposes. Religious viewpoints and practices generally do not clash with the practice of public health. Additionally, there will be times when the question of what is the most effective health intervention or policy cannot be answered adequately by the current state of science. In these instances, allowing the unfettered practice of religion is appropriate and comports with international human rights standards.

This article analyzes the relationship between religion and health, the scope of relevant international human rights law, and a few salient situations in which religious practice and health may conflict. Part I examines the multifaceted and largely unexplored relationships between health and religion. Part II outlines the development and current state of the rights to religion and health as defined in international human rights law. Finally, Part III assesses the relationship between the right to health and the right to religion under human rights law, and applies our analysis to three scenarios in which religious practice and health may conflict.

I. THE GLOBAL IMPACT OF RELIGION ON HEALTH

Religion plays an important role in the lives of much of the world's population. Certainly, members of religions believe in a religion's tenets and adhere to its practices to varying degrees. Nonetheless, religion shapes many facets of our everyday lives. Religion affects decisions that people make about their healthcare and impacts health in many direct and indirect ways. As this paper focuses on situations in which religious practices protected by the right to religion conflict with the right to health, we begin with a survey of the myriad instances in which religious belief and practice impact health.

The relationship between health and religion is difficult to describe for many reasons. First, there are thousands of religions.[2] In fact, it is difficult to define the term "religion."[3] Religion often becomes intertwined with culture, sometimes to the point where it is impossible to separate the two.[4] Second, within each religion, there may be several sects, each with different interpretations of teachings and practices.[5] Finally, individuals in some religions are permitted by the religion to interpret the teachings for themselves, which can lead to as many different expressions of the religion as there are adherents.[6] Because of

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2. *See* Adherents.com *at* http://www.adherents.com (last visited July 27, 2004).

3. T. Jeremy Gunn, *The Complexity of Religion and the Definition of "Religion" in International Law*, 16 HARV. HUM. RTS. J. 189, 190-91 (2003) (noting that, as a matter of international law, religion is not defined and that philosophers and religious scholars also have difficulty defining the term).

4. This fact explains the geographical differences in customs and practices of religions, such as the differences in Islam between Muslims in Africa and those in the Middle East, between Ashkenazic and Sephardic Jews, and between Christians in the United States and those in Southeast Asia.

5. In Christianity, for example, beyond the major denominations of Roman Catholicism, Protestantism (within which there are Presbyterians, Methodists, and Baptists), and Eastern Orthodox, each of which have at least 170 million adherents, there are at least 30 other churches that consider themselves part of Christianity. Adherents.com, *supra* note 2. Within Islam, there are at least four major branches, the two largest being Sunni and Shiite. *Id.*

6. For example, in all sects of Judaism other than Orthodox, Jews are encouraged to make their own choices about religious practice. *See* ANITA DIAMANT & HOWARD COOPER, LIVING A JEWISH LIFE: JEWISH TRADITIONS, CUSTOMS AND VALUES FOR TODAY'S FAMILIES 7-9 (1991) ("There is no Jewish Vatican, no ultimate arbiter of Judaism."). Shi'ite Muslims follow the concept of *ijtihad*, whereby certain jurists are entitled to analyze and make decisions about problems not covered specifically in the Koran, the *hadith*, or the *ijma*, or scholarly consensus. There is an ongoing debate among Islamic scholars as to whether Sunni Muslims "closed the door" to *ijtihad* or whether it remains open for them as well. Entry for "ijtihad," BRITANNICA

this plurality, it is difficult to ascribe with certainty a given health-related decision, or the genesis of a health-related law, to any particular religion. However, on a more practical level, rituals or teachings that influence health are often ascribed to religious beliefs, both by the practitioners and by independent observers.

There are numerous ways in which religions support practices that promote public health.[7] Religions generally promote respect for one's body. Christianity in general advocates the belief that all human life is sacred.[8] On the basis of the belief that humans are created in the image of God[9] as well as the belief that every human life is a life for which Jesus sacrificed himself, Christians place great emphasis on the sanctity of life. For example, the Catholic Church's prohibition of suicide follows from these beliefs.[10]

CONCISE ENCYCLOPEDIA, *at* http://www.britannica.com/ebc/article?eu=393107 (last visited July 27, 2004); Knut S. Vikør, *The Development of ijtihad and Islamic Reform, 1750-1850*, *in* THE THIRD NORDIC CONFERENCE ON MIDDLE EASTERN STUDIES: ETHNIC ENCOUNTER AND CULTURE CHANGE (1995), *at* http://www.hf.uib.no/i/smi/paj/Vikor.html (last visited July 27, 2004).

7. *See* Dr. Hussein A. Gezairv, WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN, THE ROLE OF RELIGION AND ETHICS IN THE PREVENTION AND CONTROL OF AIDS (Health Education through Religion Series, 1992) ("God has then urged man to preserve his health, and warned him against exposing himself to danger or destruction. . . . Religious teachings have given as much attention to the health and well-being of society as they have to that of the individual person. . . . In all divine messages we find numerous statements instituting concepts of health protection and disease prevention, and highlighting forms of sound life, as well as regulations to bring the enjoyment of freedom and human rights within proper limits."). It should be noted that the following discussion of the positive and negative impacts of religion on health is not intended to be exhaustive. The aim is merely to illustrate both aspects. Moreover, the authors have no view on whether one religion is more or less positive or harmful than others; multiple examples from one religion, or exclusively positive or negative examples of one religion, are purely coincidental. It is noteworthy that many of the ways in which religion negatively affects health disproportionately impact women.

8. KEITH WARD, CHRISTIANITY: A SHORT INTRODUCTION 126 (2000).

9. CATECHISM OF THE CATHOLIC CHURCH ¶¶ 1701-1702 (2d ed. 2000) [hereinafter CATECHISM]. The Catechism is a compendium of Catholic doctrine about faith and morals, developed by a commission of cardinals and bishops. Its purpose is to "convey the essential and fundamental content of the Catholic faith and morals." Editorial Commission of the Catechism of the Catholic Church, *Informative Dossier, Catechism of the Catholic Church: Characteristics*, Vatican City, *available at* http://www.usccb.org/catechism/general/dossier.htm (June 25, 1992).

10. CATECHISM, *supra* note 9, ¶¶ 2280, 2325. In place of suicide, the church promotes health and encourages those in need to obtain assistance rather than terminating their lives.

The tenets of Islam also promote respect for one's body and health.[11] For example, Islam prohibits the consumption of alcohol.[12] Such a prohibition can have multiple beneficial effects from a public health perspective, including the reduction of alcoholism and its related negative effects.[13] Islamic religious doctrine also promotes personal hygiene and healthy eating,[14] and encourages the use of medical treatments when necessary.[15]

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11. *See, e.g.*, Ruth Ohm, *The African American Experience in the Islamic Faith*, 20 PUBLIC HEALTH NURSING 478, 484 (2003).

12. The Koran is the basic text of Islam. It has three passages on alcohol, including: "They question thee about strong drink and games of chance. Say: In both is great sin, and (some) utility for men; but the sin of them is greater than their usefulness." KORAN, *Surah* II:219; *see also* KORAN, *Surah* IV:43 ("O ye who believe! Draw not near unto prayer when ye are drunken, till ye know that which ye utter, ..."); KORAN, *Surah* V:90-91 ("O ye who believe! Strong drink and games of chance and idols and divining arrows are only an infamy of Satan's handiwork. Leave it aside in order that ye may succeed. Satan seeks to stir up enmity and hatred among you by means of intoxicants and gambling, and to keep you from the remembrance of God and from your prayers. So, will you not, then, desist?").

13. From a public health perspective, banning alcohol could reduce injuries caused by altered perceptions (e.g., car accidents), aggressive behavior caused by the alcohol (e.g., domestic violence), and resulting health risks (e.g., alcoholism, liver disease). It is estimated that problems associated with alcohol use cost 100,000 lives and $184.6 billion annually in the United States alone. SECRETARY OF HEALTH AND HUMAN SERVICES, 10th Spec. Rep. to the U.S. Cong. on Alcohol and Health xi (June 2000), *available at* http://www.niaaa.nih.gov/publications/10report/intro.pdf; *see id.* at ix ("Domestic violence, child abuse, fires and other accidents, falls, rape, and other crimes against individuals such as robbery and assault – all are linked to alcohol misuse."). Further, the prohibition on the consumption of alcohol in Islam is considered by many to extend to hallucinatory drugs.

14. The requirement to eat healthfully applies in terms of quality and quantity of the food consumed. The Koran contains the following passages: "Eat of the good things which We have provided for you." KORAN, II:172. "Eat of what is lawful and wholesome on the earth." Koran, II:168. "Eat and drink, but avoid excess." KORAN, XX:81. According to Islam, Muslims should eat a diet balanced in quantity so as to avoid diseases of the digestive system, "diseases of affluence" (e.g., diabetes, hypertension, vascular disease), and diseases of the brain arteries. MUHAMMED HAYTHAM AL KHAYAT, WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR THE MEDITERRANEAN, *Health: A Blessing from God, in* HEALTH: AN ISLAMIC PERSPECTIVE (1997). According to a *hadith*, which is a saying or story of the Prophet Muhammad, the Prophet said: "It is sufficient for a human being to have a few bites to keep himself fit" (which means that it is sufficient to have only what one needs to maintain strength and well-being). *Id.*

15. In one *hadith*, the Prophet is quoted as saying: "Seek medical treatment." In another, he said: "God has not created a disease without creating a cure for it." He also encouraged research and development by the medical profession, as the following *hadith* demonstrates: "Every disease has a cure. If treatment is administered with the right cure, the patient will recover by God's grace." Another version of this *hadith* states "God has not created a disease without creating a cure for it, which may be known to some and unknown to others." *See* AL KHAYAT, *Setting the Balance, in* HEALTH: AN ISLAMIC PERSPECTIVE, *supra* note 14.

Judaism also has a number of tenets that have positive implications for public health. One is that people's bodies are merely lent to them by God for the duration of their lives; since God continues to own the bodies, Jewish people are required to take proper care of them.[16] There are rules that govern such health-related activities as hygiene, sleep, exercise, and diet.[17] Jews are also required to try to avoid danger and injury as much as possible.[18] Based on the obligation to avoid conduct that unnecessarily endangers one's health, smoking[19], illegal drugs,[20] tattooing,[21] and suicide[22] are widely considered to be prohibited.

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16. *See* ELLIOT N. DORFF, MATTERS OF LIFE AND DEATH: A JEWISH APPROACH TO MODERN MEDICAL ETHICS 15 (1998).

17. *See id.* According to Maimonides, "A man should aim to maintain physical health and vigor in order that his soul may be upright, in a condition to know God. . . . Whoever through his life follows this course will be continually serving God . . . ." *Id.* at 26 (quoting MAIMONIDES, MISHNEH TORAH, Laws of Ethics (De'ot) 3:3). In Judaism there is an elaborate system of dietary laws called *kashrut*, which prohibits the consumption of certain foods entirely and sets out rules regarding the combinations in which other foods may be eaten. Many Jewish scholars believe that *kashrut* is designed to maintain health by prohibiting dangerous and dirty foods. *See id.* at 247.

18. *See id.* at 18 (citing, *inter alia*, BABYLONIAN TALMUD, *Shabbat* 32a (Ravina & Ravi Ashi eds., 500); MAIMONIDES, MISHNEH TORAH, Laws of Murder II:4-5).

19. Smoking is prohibited in the Conservative and Reform movements and by some Orthodox authorities. *See id.* Also consider the following remarks made by the Associate Director of the Religious Action Center of Reform Judaism:

> Jewish tradition teaches that we are all created b'tzelem elohim—in the image of God—making each human life as precious as the next. The Torah instructs us to "choose life," and . . . to avoid things that are detrimental to the body and health and to condition the body to things that heal and fortify it. . . . The use of tobacco . . . is a betrayal of our obligation to seek full and healthy lives.

Press Release, Mark J. Pelavin, Associate Director, Religious Action Center of Reform Judaism, on President Clinton's Executive Order Aimed at Curbing Underage Smoking (August 23, 1996), *available at* http://rac.org/news/smoke.html. The Religious Action Center is the Washington office of the Union of American Hebrew Congregations and the Central Conference of American Rabbis, representing 1.5 million Reform Jews and 1,700 Reform rabbis in 850 congregations throughout North America. *Id.*

20. Hallucinatory drugs are also prohibited. DORFF, *supra* note 16, at 251 (stating that hallucinatory drugs are prohibited due to their illegality under civil law, the risk of endangering oneself and others through conduct while under the influence, and the detrimental health effects to the user).

21. According to the Torah, "You shall not make gashes in your flesh for the dead, or incise any marks on yourselves: I am the Lord." *Leviticus* 19:28. While there are statements in the Torah and those of Talmudic scholars suggesting that this proscription is limited or should be understood differently, the vast majority of Jewish people operate under the belief that tattooing is prohibited. *See* DORFF, *supra* note 16, at 267-269.

22. DORFF, *supra* note 16, at 18 ("Judaism also teaches that human beings do not have the right to dispose of their bodies at will (that is, commit suicide), for to do so would totally

Hinduism and Buddhism both attach significant importance to health. Hindus believe that spirituality encompasses a sound mind and a sound body; some adherents practice yoga on a daily basis in order to develop physical fitness and mental strength.[23] Meditation is used in Hinduism to focus on the essence of Brahman, the Absolute in Hinduism, within the practitioner.[24] It is well known that meditation has many beneficial health effects, including relaxation, sound sleep, general physical health, and happiness (which, in turn, can impact physical and mental health).[25]

Meditation is also used in Buddhism, where health is considered "the best gain."[26] Buddhists strive to "train the mind to understand the mental state of happiness, to identify and defuse sources of negative emotion and to cultivate emotional states like compassion to improve personal and societal well-being."[27] They believe that illnesses tend to arise when the delicate equilibrium between the mind and body, and that between life and the environment, is upset. To restore this balance, Buddhism employs various forms of holistic medicine and psychosomatic approaches.

Many religions also promote respect for others. For example, the principle of non-violence called *ahimsa* is common to Buddhism, Jainism, and Hinduism.[28] The observance of this principle leads some

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obliterate something that belongs not to us but to God.") (citing Genesis 9:5).

23. JEANEANE FOWLER, HINDUISM: BELIEFS AND PRACTICES 50 (1997).

24. *See id.*

25. *See* WALPOLA RAHULA, WHAT THE BUDDHA TAUGHT 71 (2d ed. 1974) (physical health, relaxation, sound sleep); *Buddhists "Really are Happier,"* BBC NEWS (ONLINE), May 21, 2003, *at* http://news.bbc.co.uk/2/hi/ health/3047291.stm (happiness).

26. RAHULA, *supra* note 25, at 131 (citing THE WORDS OF TRUTH, selections from The Dhammapada, #204).

27. Stephen Hall, *Is Buddhism Good for Your Health?*, N. Y. TIMES MAG., Sept. 13, 2003, at 46.

28. COLUMBIA ENCYCLOPEDIA, 6th ed., entry for *ahimsa*, *available at* http://www.encyclopedia.com/ html/a1/ahimsa.asp (last visited on December 9, 2003). Mahatma Gandhi is probably the most well-known follower and proponent of *ahimsa*. The Dalai Lama, the spiritual leader of Tibetan Buddhism and another practitioner of *ahimsa*, describes it as follows: "Non-violence is related to a sense of compassion and a sense of caring. Compassion is not a feeling of pity. Compassion is a genuine sense of responsibility and respect for all beings. So, affectionate emotions and compassionate caring are the foundation of human survival. Therefore, non-violence goes very well with our basic human nature." Dalai Lama, *Ahimsa is very [practical]: The Dalai Lama explains why non-violence leads to lasting happiness*, JAIN SPIRIT ONLINE, *at* http://www.jainspirit.com (last visited July 28, 2004).

to become vegetarians (in order to respect animals)[29] and others to restrict their diet to only certain vegetables.[30] Ahimsa has a positive influence on public health as it supports practices designed to facilitate one's own health and prevent violence to others. Christianity promotes respect for others as well. For example, Catholic social teachings promote social and economic justice.[31]

Several religions have healthful practices and policies regarding sexual relationships. Many religions require monogamy and/or faithfulness within marriage.[32] These traditions reduce the spread of sexually transmitted infections and may provide stable social environments. Some religions also take a proactive stance toward sexual education and birth control. For example, contraception is permitted in Judaism.[33] In fact, modern Jewish thinking requires the use of condoms during sexual relations if there is any risk of sexually transmitted infection due to the previous sexual or medical history of either partner; in this case, the duty of Jewish males to procreate is considered to be outweighed by the duty of all Jews to maintain life and health.[34]

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29. *See, e.g.*, FOWLER, *supra* note 23, at 65-66 (noting that a large number of Hindus are vegetarians).

30. Jainism recognizes the five senses as the principal attributes of living beings and has classified all creatures in terms of the senses that they have. Jains eat only those life forms that have only one sense, which is basically plant life. In order to reconcile the principle of *ahimsa* with their diet and to preserve plant life as much as possible, there are strict dietary rules for day-to-day living. These include prohibition of the consumption of some vegetables and fruits, restrictions on procurement of produce, restrictions on the timing of eating, and fasting. P K Jain, *Dietary Code Of Practice Amongst Jains*, 34th World Vegetarian Congress, Toronto, Canada, *available at* http://www.ivu.org/congress/2000/jainism.html (July 10-16, 2000).

31. *See, e.g.*, U.S. Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (1986), *available at* http://www.osjspm.org/cst/eja.htm ("The life and words of Jesus and the teaching of his Church call us to serve those in need and to work actively for social and economic justice. As a community of believers, we know that our faith is tested by the quality of justice among us, that we can best measure our life together by how the poor and the vulnerable are treated."). The Catholic bishops opined that justice requires that all people be assured a minimal level of participation in the economy, including access to employment and the ability to provide for themselves. *Id.* These teachings promote public health by promoting respect for others and encouraging assistance to more vulnerable populations.

32. *See, e.g.*, THOMAS C. FOX, SEXUALITY AND CATHOLICISM 14 (1995) (Christianity, including Catholicism); SUZANNE HANEEF, WHAT EVERYONE SHOULD KNOW ABOUT ISLAM AND MUSLIMS 158 (14th ed. 1996) (Islam).

33. *See* DORFF, *supra* note 16, at 120-22.

34. *See id.*

Another way in which the practice of religion may have a positive impact on health is through prayer. A significant amount of scientific research has been conducted on the effect of prayer on health and, though controversial, this research has become a popular topic for books, conferences, and radio shows.[35] While a 1997-98 study indicated improved health outcomes for patients for whom others prayed compared to a control group,[36] a more recent and much larger study did not support such findings.[37] Much less controversial is the notion that personal religious belief can improve a person's mental health, by increasing peace of mind and providing solace.[38]

Religious teachings that encourage charity also support public health. Christianity, Islam, Judaism, Hinduism, Buddhism and many other

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35. *See, e.g.*, LARRY DOSSEY, HEALING WORDS: THE POWER OF PRAYER AND THE PRACTICE OF MEDICINE (1993); HAROLD G. KOENIG, THE HEALING POWER OF FAITH: SCIENCE EXPLORES MEDICINE'S LAST GREAT FRONTIER (1999); Dianne Hales, *Why Prayer Could Be Good Medicine*, PARADE, March 23, 2003; Stuart M. Butler et. al, *Is Prayer Good for Your Health? A Critique of the Scientific Research*, lecture sponsored by the Heritage Foundation (Lecture #816) (Dec. 22, 2003), *available at* http://www.heritage.org/Research/Religion/HL816.cfm; The Tavis Smiley Show, *Power of Prayer*, (National Public Radio broadcast) (Mar. 26, 2003), *available at* http://www.npr.org/features/ feature.php?wfId=1206323.

36. Duke University Medical Center, *Prayer, Noetic Studies Feasible; Results Indicate Benefit to Heart Patients*, *at* http://www.dukemednews.duke.edu/news/article.php?id=5056 (Oct. 31, 2001).

37. *"No Health Benefit" From Prayer*, BBC NEWS (ONLINE), Oct. 15, 2003, *at* http://news.bbc.co.uk/2/hi/health/3193902.stm; Mark Henderson, *Junk medicine: Miracle cures*, THE TIMES (LONDON), Nov. 1, 2003, at Features, Body & Soul 4. In both studies, patients who were having angioplasty surgery were randomly split into two groups. Prayer groups of varying denominations around the world (e.g., Buddhists, Catholics, Moravians, Jews, Fundamentalist Christians, Baptists and members of the Unity School of Christianity) prayed for one group of patients. The first study, which involved 150 subjects, suggested that there were between 25 and 30 percent fewer occurrences of "adverse outcomes" (e.g., death, heart failure, heart attack) in the group of patients toward whom prayer was directed. *See* Duke University Medical Center, *supra* note 36. The second study, which was dubbed the "Mantra Study" and involved 750 subjects, suggested otherwise – that the group of patients who received prayer fared no better than the other group. *See* BBC NEWS, *supra* this note. Both studies were conducted by Duke University Medical Center. The study received criticism from some religious leaders, who argued that people should not test God, and also from people challenging the idea that "doses" of prayer could be measured, pointing out that plenty of those in the group of patients toward whom prayer was not directed most likely did receive prayers from family and friends. *See* Henderson, *supra* this note.

38. *Praying "Aids Mental Health,"* BBC NEWS (ONLINE), Nov. 12, 1999, *at* http://news.bbc.co.uk/2/hi/health/ 516350.stm; Butler, *supra* note 35 (discussing the results of studies indicating the positive effect of prayer on mental health).

religions encourage their followers to engage in charity.[39] Religious charities can have a significant impact on the health of those less fortunate in society, for example, through soup kitchens, food and clothing drives, building of homes, medical clinics, and donations to organizations that provide services to the needy. In developing countries, religious charities and missionaries—such as Catholic Relief Services, Unitarian Universalist Service Committee, United Methodist Committee on Relief, American Friends Service Committee, and Islamic American Relief Agency—often are responsible for the creation of hospitals, hospices, and other facilities that provide medical services and access to health care that may not otherwise be available.[40] Many of these organizations also provide humanitarian assistance following natural disasters, civil wars, and other events that create crisis conditions in terms of meeting a population's basic needs for sustenance and health.

There are many more ways in which religious ideation promotes public health. However, there are also several instances in which religious teachings can have a detrimental impact on the health of the

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39. *See, e.g.*, WARD, *supra* note 8, at 115 (pointing to Jesus's mandate that "everyone is our neighbor" in Luke 10:29-37); THOMAS BOKENKOTTER, ESSENTIAL CATHOLICISM: DYNAMICS OF FAITH AND BELIEF 286-288 (1985); DORFF, *supra* note 16, at 26 (Judaism); HANEEF, *supra* note 32, at 58-61 (Islam); YASUJI KIRIMURA, FUNDAMENTALS OF BUDDHISM 22-23 (2d ed. 1984).

According to the Koran, "It is not righteousness that you turn your faces toward the East or the West but righteousness is that one believe in God and the last day and the angels and the Book and the prophets; and (that he) give his wealth out of love for Him for kinsmen, orphans, the needy . . . and (that he) give salah and give Zakah." KORAN, 2:177. *Zakah*, one of the five pillars of Islam (along with the declaration of faith, the prescribed prayers, fasting during Ramadan, and the pilgrimage to Mecca) is "the Muslim's worship of God by means of his wealth through an obligatory form of giving to those in need." HANEEF, *supra* note 32, at 58-61. *Salah* are the prayers that Muslims offer five times daily.

Charity also plays an important role in Catholicism, with "love thy neighbor as yourself" as the second of the Ten Commandments of the religion. Catholics are obligated to promote the welfare of their neighbor, who is defined broadly as anyone in need. BOKENKOTTER, *supra* this note, at 286-288.

40. For information on the work of these charities, see http://www.catholicrelief.org (Catholic Relief Services), http://www.uusc.org/ (Unitarian Universalist Service Committee), http://www.umcor-ngo.org/ (United Methodist Committee on Relief), http://www.afsc.org/ (American Friends Service Committee), http://www.iara-usa.org/ (Islamic American Relief Agency). For example, Catholic Relief Services (CRS) operates AIDS projects that serve two million people in over forty countries. The programs are focused in Africa and provide care to those living with AIDS as well as support to orphans and children. CRS, HIV/AIDS Programming, *at* http://www.catholicrelief.org/our_work/what_we_do/programming_areas/AIDS/CRS_focus/index.cfm.

adherents of a particular religion, or those with whom they come into contact. These situations often concern norms related to sexuality and procreation; rites of passage; and the prescribed gender roles within a religious culture.

One practice that has received considerable attention recently is the Catholic Church's categorical proscription of birth control, even in the face of the AIDS pandemic. According to the Catechism of the Catholic Church, "'[E]very action which, whether in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an ends or as a means, to render procreation impossible' is intrinsically evil."[41] Adherence to this policy has health implications for the spread of sexually transmitted infections (STIs), including AIDS, since scientific evidence clearly establishes that condoms, when used correctly, reduce significantly the spread of STIs.[42] Aggravating the danger of this policy to the health of followers, and those who are intimate with them, some officials of the Catholic Church have engaged in a campaign of misinformation that promotes the idea that condoms are not effective in preventing the spread of AIDS.[43]

Another situation in which religious doctrine or practice has a negative impact on health is the practice of female genital circumcision (often referred to as female genital mutilation or FGM),[44] which involves the partial or total cutting away of female genitals.[45] FGM continues to be widely practiced in areas of Africa and the Middle East, including Egypt. Surveys have found that ninety-seven percent of Egyptian women have undergone the practice.[46] While FGM is most

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41. CATECHISM, *supra* note 9, ¶ 2370.

42. *See infra* notes 202-205 and accompanying text.

43. *See infra* notes 214-215 and accompanying text.

44. In the majority of recent literature on this procedure, the practice is referred to as female genital mutilation, or FGM. We have chosen to abide by this custom.

45. CENTER FOR REPRODUCTIVE RIGHTS, FACTSHEET ON FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION (FC/FGM): LEGAL PROHIBITIONS WORLDWIDE (Item F027, Feb. 2004), *available at* http://www.crlp.org/ pub_fac_fgmicpd.html [hereinafter CPR FACT SHEET ON FGM].

46. UNITED NATIONS DEVELOPMENT PROGRAM NEWSFRONT, *Egyptian Coalition Mobilizes Against Custom that Harms Women and Girls*, Jan. 27, 2003. FGM is typically carried out on a girl anytime between one week and fourteen years of age. The procedure generally is performed by a midwife and is conducted without the use of even a local anesthetic. The child is held down by several women during the procedure. STEINER & ALSTON,

often discussed as a cultural practice, many people who perform or undergo the procedure believe that they are complying with a practice mandated by Islam.[47]

The negative health implications associated with female circumcision are extensive. They include: hemorrhage and shock from acute pain; possible infection of the pelvis during the procedure; inflammation and blocking of fallopian tubes; acute, often fatal, bleeding; possible sterility; complications with childbirth, including obstructed delivery and increased risk of fetal brain damage and fetal loss; adverse effects on the urinary system, including the risk of developing a urinary fistula, which causes retention of the urine and menstrual blood; depression, nervous tension, and anxiety; and difficulty and pain during intercourse.[48]

Refusal of medical treatment on religious grounds is another health risk resulting from religious tenets. The refusal of Christian Scientists to accept medical treatment for themselves or their children has garnered much media attention in the United States over the past decade.[49] Christian Scientists believe that, since people are perfect spiritual

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INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 242 (1996) (citing *A Traditional Practice that Threatens Health—Female Circumcision*, WHO CHRONICLE 31 (1986)).

47. There is evidence of the Islamic grounding of FGM, although its authenticity is disputed. *See infra* notes 247-251. People who dispute the Islamic basis for FGM point to the fact that it is not practiced in Saudi Arabia, the birthplace of the Prophet Muhammad.

48. *See, e.g.*, STEINER & ALSTON, *supra* note 46, at 242-43; WORLD HEALTH ORGANIZATION, FEMALE GENITAL MUTILATION FACT SHEET NO. 241 (June 2000) [hereinafter WHO FACT SHEET ON FGM].

49. *See, e.g.*, Janna C. Merrick, *Spiritual Healing, Sick Kids and the Law: Inequities in the American Healthcare System*, 29 AM. J. L. & MED. 269 (2003); Jessica Reaves, *Freedom of Religion or State-Sanctioned Child Abuse? Rising Death Toll Fuels Debate over Parents who Choose Prayer over Medical Treatment on Behalf of Their Children*, TIME (ONLINE EDITION), Feb. 21, 2001, *available at* http://www.time.com/time/nation/article/0,8599,100175,00.html; Seth M. Asser & Rita Swan, *Child Fatalities From Religion-motivated Medical Neglect*, 101 PEDIATRICS 625-629 (April 1998); Caroline Fraser, *Suffering Children and the Christian Science Church*, THE ATLANTIC MONTHLY (ONLINE), April 1995, *available at* http://www.theatlantic.com/unbound/flashbks/xsci/suffer.htm.

Jehovah's Witnesses, while accepting almost all medical treatments, do not accept blood transfusions. This is based on a biblical verse that commands people to abstain from blood. "Blood—Vital for Life," *at* http://www.watchtower.org/library/hb/index.htm?article=article_01.htm (Jehovah's Witnesses official website) (last visited July 28, 2004).

For a discussion of religious-based refusals to obtain vaccinations, see *infra* section III.C.

likenesses of God, disease and illness can only be caused by a person living apart from God and that, through prayer, a person can come closer to God and be healed.[50] They generally believe that prayer is the first and only step of treatment for themselves and their children and, as a result, forgo medical treatment.[51] The refusal to obtain medical treatment can lead to serious health implications, including death.[52]

There are two practices rooted in Hindu religious doctrine that have a significant negative impact on the health of women and girls.[53] First,

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50. In *Science and Health with Key to the Scriptures*, the principle text of the Christian Science religion, Mary Baker Eddy (the religion's founder) wrote the following next to the title "Treatment of Disease":

> 'Agree to disagree' with approaching symptoms of chronic or acute disease, whether it is cancer, consumption, or smallpox. Meet the incipient stages of disease with as powerful mental opposition as a legislator would employ to defeat the passage of an inhuman law. Rise in the conscious strength of the spirit of Truth to overthrow the plea of mortal mind, *alias* matter, arrayed against the supremacy of Spirit. Blot out the images of mortal thought and its beliefs in sickness and sin. Then, when thou art delivered to the judgment of Truth, Christ, the judge will say, 'Thou art whole!'

MARY BAKER EDDY, SCIENCE AND HEALTH WITH KEY TO THE SCRIPTURES 390 (2000); *see also id.* at 335 ("Sin, sickness, and mortality are the suppositional antipodes of Spirit, and must be contradictions of reality."); *id.* at 420 ("Tell the sick that they can meet disease fearlessly, if they only realize that divine Love gives them all power over every physical action and condition."); *id.* at 476-77 ("Jesus beheld in Science the perfect man, who appeared to him where sinning mortal man appears to mortals. In this perfect man the Saviour saw God's own likeness, and this correct view of man healed the sick."); "Christian Science," *at* http://www.beliefnet.com/index/index_10123.asp; "The Church of Christ, Scientist," *at* http://www.religioustolerance.org/cr_sci.htm.

51. "Christian Science," *supra* note 50; "The Church of Christ, Scientist," *supra* note 50.

52. As many as 172 children reportedly died between 1975 and 1995 as the result of decisions made by their parents to refuse medical care based on religious beliefs. Many of the children would have survived and recovered with the help of antibiotics. Reaves, *supra* note 49.

53. A third social issue being confronted in Hindu cultures (primarily in India) is "dowry deaths," whereby a married woman is killed – often burned alive – by her husband or his family based on frustration over the terms or payment of her dowry. *See generally* MALA SEN, DEATH BY FIRE: SATI, DOWRY DEATH AND FEMALE INFANTICIDE IN MODERN INDIA (2001). Although the relationship between religion and custom is complicated, it is widely accepted that the custom of dowry, whereby the bride's family gives money and/or property to the groom's family, is rooted in Hinduism. Judith G. Greenberg, *Criminalizing Dowry Deaths: The Indian Experience*, 11 AM. U. J. GENDER SOC. POL'Y & L. 801, 826-29 (discussing the ongoing debate over the role of the British colonial government in the standardization of the custom of dowry); Indra Chopra, *Marriage: A Retail Outlet,* India Together (Apr. 2003), *at* http://www. india together.org/women/dowry (describing the origins of the practice in the ancient Hindu customs of *kanyadan*, whereby the bride's father offered money or property to the father of the groom, and *stridhan*, whereby the bride was given jewelry and clothes upon marriage, usually from

the practice of *sati* calls for Hindu widows to join their recently deceased husbands on the funeral pyre in an act of self-immolation.[54] In this traditional rite, the woman stabs herself with a *kris* (dagger with a wavy blade) while wearing her wedding dress.[55] Although Hindu doctrine characterizes *sati* as "the highest duty of a woman,"[56] and women who commit *sati* are treated as goddesses,[57] this practice is no longer common in Hindu culture.[58]

Second, the prominent role that boys and men play in Hindu society as compared to girls and women has given rise to the practice of female infanticide.[59] The methods are often gruesome, including choking the

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relatives or friends).

According to the Indian National Crime Records Bureau, there were 6,995 recorded dowry deaths in India in 2000. The actual figure is considered to be much higher due to underreporting. Soma Wadhwa, *Difficult Customer*, OUTLOOK (May 26, 2003), *available at* www.outlookindia.com. The number of married women world-wide who are killed or maimed over dowry disputes each year is estimated to be over 25,000. Himendra Thakur, *Are Our Sisters and Daughters for Sale?*, India Together (June 1999), *at* http://www.indiatogether .org/women/dowry. For a discussion of the ongoing custom of dowries and dowry-related violence, see generally Celia W. Dugger, *Kerosene, Weapon of Choice For Attacks on Wives in India*, N.Y. TIMES, Dec. 26, 2000, at A1; Chopra, *supra* this note.

54. *See generally* CATHERINE WEINBERGER-THOMAS, ASHES OF IMMORTALITY: WIDOW-BURNING IN INDIA (Jeffrey Mehlman & David G. White trans., The Univ. of Chi. Press 1999) (1996); SEN, *supra* note 53.

55. WEINBERGER-THOMAS, *supra* note 54, at 5-12.

56. Brahma Purana 80.75. The eighteen major devotional works that comprise the *Puranas* are part of the scriptures of devotional Hinduism. *See* FOWLER, *supra* note 23, at 127-28. Hindu doctrine also suggests that celibacy is the only alternative to *sati* following the death of a woman's husband. *See* Visnu Dharma Sastra XXV.14. The Dharma Satras, or law books, are part of the Vendangas, which are also part of the scriptures of devotional Hinduism. *See* FOWLER, *supra* note 23, at 128.

57. Jyotsna Kamat, *The Tradition of Sati in India*, Kamat's Potpourri (Aug. 15, 1997), *at* http://www. kamat.com/kalranga/hindu/sati.htm. Even in the few recent cases of *sati*, women have flocked to the sites in order to worship. *See infra* note 58.

58. One researcher of the practice estimates that there have been forty occurrences of *sati* in India since independence. WEINBERGER-THOMAS, *supra* note 54, at 183. This number has decreased dramatically since the 1800s, when hundreds of women engaged in *sati* each year. *Id.* at 208 (providing data that, for example, in 1821, 654 women conducted self-immolation). Two recent cases of *sati*—one in the late 1980s and one in August 2002 – have attracted widespread international attention. *Indian woman dies on husband's pyre*, BBC NEWS (ONLINE), Aug. 6, 2002, *at* http://news.bbc.co.uk/2/hi/south_asia/2176885.stm.

59. In Hinduism, the birth of a boy is much more important than the birth of a girl for both religious and cultural reasons. First, more prestige is attached to giving birth to a boy. Second, under Hindu belief, a Hindu male cannot progress to the next stage of life until he has had a boy. Third, the performance of death rites by a boy child is believed to result in a better reincarnation for his parents. Fourth, boys are an economic advantage because families have

infant with salt or sand, tearing her intestines with a meal of coarse grain, and rubbing poison on the mother's breasts.[60] Female infanticide is a widespread phenomenon in India and, together with increased abortion of female fetuses,[61] and female infant mortality due to neglect,[62] has resulted in a skewed ratio of boys to girls in India. There are now eight percent more males than females in India today.[63] Aside from the grave health implications for mothers and female newborns and children,[64] the practice of infanticide is likely to have far-reaching social implications in India.[65]

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to pay a dowry when a female gets married and leaves the home, while male children remain and continue contributing to the household; families of male children who marry will also receive a dowry. *See* FOWLER, *supra* note 23, at 52.

60. Madhu Gurung, Female Foeticide, *at* http://www.hsph.harvard.edu/Organizations/healthnet/ SAsia/forums/foeticide/articles/foeticide.html (last visited July 28, 2004); *see also* Kirsten M. Backstrom, Note, *The International Human Rights of the Child: Do They Protect the Female Child?*, 30 GEO. WASH. J. INT'L L. & ECON. 541, 544 (listing as methods drowning, abandonment, starvation, or inadequate postnatal care leading to fatal disease or malnutrition).

61. With the development of amniocentesis technology has come increased use of the test for pre-natal determination of the sex of the fetus and increased abortion of female fetuses. *See* FOWLER, *supra* note 23, at 57. The Indian government banned the use of amniocentesis tests for determining the sex of a fetus in 1994, *see id.*, but the ban only made the tests go underground and become more costly. *See* Gurung, *supra* note 60; *see also* Andrea Krugman, *Being Female Can be Fatal: An Examination of India's Ban on Pre-Natal Gender Testing*, 6 CARDOZO J. INT'L & COMP. L. 215 (1998); Celia W. Dugger, *Abortions in India Spurred by Sex Test Skew the Ratio Against Girls*, NY TIMES, April 22, 2001, at A12.

62. Backstrom, *supra* note 60, at 544 (noting that girls who are not killed outright after their birth often die within their first few years as a result of discriminatory cultural practices that increase their risk of death).

63. *Id.* The UN Population Fund (UNFPA) issued a report with the government of India in October 2003 on the "decade of 'missing' girls" in India. OFFICE OF REGISTRAR-GENERAL AND CENSUS COMMISSIONER, INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE [OF INDIA], AND UNFPA, MISSING: MAPPING THE ADVERSE CHILD SEX RATIO IN INDIA (June 2003), *available at* http://www.unfpa.org.in/publications/ 16_Map%20brochure_English.pdf [hereinafter MISSING]. According to the report, data show a decline in the number of girls compared to boys in India during the last decade; the report attributes the relative decline to the elimination of girls by sex-selective abortion and infanticide. *Id.* at 1 (referring to the practice of sex-selective abortion as "pre-birth elimination of females (PBEF)"). *Id.* at 21 (offering case studies of women who committed infanticide of female babies); *see also* Press Release, UNFPA Calls Decade of "Missing" Girls, Discrimination, Alarming (Oct. 28, 2003), *at* http://www.unfpa.org/news/ news.cfm?ID=388&Language=1.

64. *See, e.g.*, Gurung, *supra* note 60 ("The demand for sons has created a whole new medical industry, ranging from dubious 'miracle drugs' to expensive and unsafe tests conducted by unqualified medical personnel, followed by abortions in ill equipped clinics under hazardous conditions.").

65. *See* MISSING, *supra* note 63, at 1 ("A stage may soon come when it would become extremely difficult, if not impossible, to make up for the missing girls. . . . [M]issing members

Another example of religious doctrine and practice that results in negative health consequences for women is the subjugation and persecution of women that occurred under the form of Islam espoused by the Taliban. The Taliban emerged in 1994, developing from a movement of Pashtun youths and students that began in religious schools in Pakistan. Although the Taliban have been removed from power in Afghanistan, the policies they enacted continue to have health consequences for women.[66] Under Taliban rule, *inter alia*, women could not work outside their homes; they could not leave their homes except in the company of a close male relative; education for girls over the age of eight years old was terminated; women were required to cover themselves from head-to-toe in a *chadari*, a body-length covering with only a mesh opening through which to see and breathe; segregated health services existed for men and women; and medical examinations of women by male doctors were prohibited absent a chaperone.[67]

The dire health consequences of the Taliban policies have been documented through surveys conducted by the human rights organization Physicians for Human Rights.[68] For example, the requirement of

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of either sex, and the resulting imbalance, can destroy the social and human fabric as we know it.").

66. *See* PHYSICIANS FOR HUMAN RIGHTS, WOMEN'S HEALTH AND HUMAN RIGHTS IN AFGHANISTAN: A POPULATION-BASED ASSESSMENT 1 (2001) [hereinafter PHR].

67. *Id.* at 19-24. When the Taliban announced the policy of segregated health care in January 1997, services for women were provided by a single hospital still partially under construction, which had neither water, oxygen, blood plasma, electricity, nor surgical equipment. Humanitarian organizations working in the city protested the edict and, after months of negotiations led by the International Committee of the Red Cross (ICRC), the Taliban partially rescinded their directive and agreed to reopen some hospitals. *Id.* at 23.

68. For example, the PHR report contained the following survey data:

> Women in the Taliban-controlled areas surveyed by PHR almost unanimously expressed that the Taliban had made their lives "much worse" (94-98%). These women reported worse physical (84% vs. 63%) and mental health (85% vs. 54%), including extremely high rates of major depression (76% vs. 28%) and suicide (16% vs. 9%), compared to women living in non-Taliban-controlled areas.

Id. at 2. Furthermore:

> PHR found a high prevalence of poor mental health, suicidal ideation (65-77%) and suicide attempts (9-16%) among study participants. More than 70% of women exposed to Taliban policy made diagnostic criteria for current major depression. There was also an increase in the prevalence of major depression over the last two years, particularly among women living under Taliban control. The majority of women (65-94%) exposed to Taliban policies attributed their symptoms of depression to official Taliban policy.

Id. at 11.

wearing a *chadari* can create eye problems and poor vision, poor hearing, skin rash, headaches, increased cardiac problems and asthma, alopecia (hair loss), and depression. Furthermore, impaired vision while wearing the *chadari* can lead to falls and increase the chances of being hit by cars while walking. Likewise, restrictions on movement, dress code requirements, and segregation of transportation facilities impeded women's access to medical care.[69] Prohibitions on women working as doctors or nurses, prohibitions on the ability of women to be examined by male doctors, and the virtual absence of mental health care further impeded the ability of women to obtain needed medical attention.[70] Moreover, the Taliban policies restricting women's education had a negative effect on women's health, limiting their ability to make "informed choices regarding health practices, accessing health care services, interacting with health care personnel and participating in treatment regimens."[71]

The foregoing discussion illustrates both the positive and negative effects that religion can have on individual and public health. Many religious practices based on respect for one's life and body, as well as respect for others, contribute positively to health for all. On the other hand, some religious practices affect health negatively.[72] The next section discusses the relationship of human rights to religion and health in order to shed light on the proper course of action to take when religious practices conflict with public health.

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69. *See id.* at 23.

70. *See id.* The large number of Afghan widows who have no male family member who could act as an escort faced an even more significant hardship in seeking medical care from a male doctor. *See id.* Under Taliban rule, there was a particular need for mental health services given the increased number of women with mental disorders caused by the war, impoverishment, and the restrictive Taliban policies toward women (including loss of employment, confinement in the home, and threat of serious physical punishment, torture or death in the event of a violation of a law). *See id.* at 24.

71. *See id.*

72. Other examples of religious practices that have unhealthy consequences for the practitioner or others include violent rites of passage in African religions and burial rituals that involve leaving the corpse outside for a length of time or disposing of it in bodies of water in which people bathe or from which people drink.

II. THE RIGHT TO RELIGION AND THE RIGHT TO HEALTH

Central to our position that laws concerning public health should take into account scientific principles, even when such principles contradict religious teaching, are the internationally recognized rights to health and to free exercise of religion.[73] Both of these rights are recognized in the Universal Declaration of Human Rights (UDHR),[74] which is widely regarded as the founding and foundational document of the human rights movement. In the years since the drafting of the UDHR, each of the rights contained therein have been interpreted to entail specific entitlements.

A. The Right to Health

The international human rights system has recognized a right to health since its origins after the conclusion of World War II. Numerous international human rights instruments, declarations, and resolutions now include the right to health. Regional human rights systems, and some national laws, also include explicit recognition of rights to health. Nevertheless, the evolution of an unambiguous, consistent, and enforceable right to health in the international system has been protracted.[75] Recent developments, including the promulgation of a United Nations General Comment that is related to the right to health, as well as the appointment of a U.N. Special Rapporteur to study the right to health, have helped to define the contours of this right.

The following section examines the development and content of the right to health under international law with a particular focus on the UN system.[76] While the right to health is a fundamental and enforceable

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73. Other human rights, such as the right to life and the right to nondiscrimination, are also clearly implicated, as will be discussed further in section III.

74. Universal Declaration of Human Rights, adopted Dec. 10, 1948, G.A. Res. 217A (III), U.N. Doc. A/810 (1948) [hereinafter UDHR].

75. For an extensive account of the development of the right to health, see BRIGIT C.A. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW 3-26 (1999).

76. While regional human rights systems in Europe, Africa, and the Americas have recognized the right to health, the right to health has been more extensively developed under the UN human rights system. Therefore, the focus of this section is on the UN system. For more information regarding regional human rights systems, see, for example, European Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, *entered into force* Sept. 3, 1953, 213 U.N.T.S. 221, Europ. T.S. 5; American Convention on

international human right, it has often been under-enforced. Nevertheless, at the beginning of the twenty-first century, the scope and substance of the right to health are better understood and more relevant than ever before.

1. *Exploring the Right*

Prior to the creation of the international and regional human rights systems, the international community did not explicitly recognize a right to health. The drafters of the UDHR and the International Covenant on Economic, Social and Cultural Rights (ICESCR)[77] incorporated into these instruments an explicit right to health, thereby affirming the importance and relevance of guaranteeing the "dignity and worth of the human person."[78]

In 1947, the international community assembled to create a document that would enunciate the basic rights and fundamental freedoms shared by all of humanity. These meetings eventually produced the UDHR, which was adopted by the UN General Assembly in 1948. The UDHR seeks to create "a common standard of achievement for all peoples and all nations" to respect and promote human rights.[79] In outlining universal human rights, the UDHR incorporates civil and political rights, as well as economic, social, and cultural rights. It describes economic, social, and cultural rights as "indispensable for [a person's] dignity and the free development of his personality."[80] Among the economic,

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Human Rights (Pact of San Jose), *signed* Nov. 22, 1969, *entered into force* 18 July 1978, OASTS 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc.21, rev.6 (1979), *reprinted in* 9 ILM 673 (1970) (Americas); African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, *entered into force* Oct. 21, 1986, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, *reprinted in* 21 I.L.M. 58 (1982) (Africa) [hereinafter African Charter]; *see also* Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons With Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20 (2004) (discussing extensively the development of human rights jurisprudence in the regional human rights systems).

77. International Covenant on Economic, Social and Cultural Rights. G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 59, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 302, *entered into force* Mar. 23, 1976 [hereinafter ICESCR].

78. UN CHARTER prmbl.

79. UDHR, *supra* note 74, prmbl.

80. *Id.* at art. 22.

social, and cultural rights included, Article 25 expressly acknowledges a right to health:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[81]

The UDHR does not legally bind states. However, its provisions have become a "common standard" for human rights protection and are now widely considered to reflect customary international law.[82] Therefore, while the provisions of the UDHR are not directly enforceable against states, they have significant political importance. These provisions inform the worldwide understanding of the human rights to which all states are politically accountable and provide a persuasive contextual framework that undergirds all subsequent human rights instruments.

In order to elucidate further the scope and content of the rights enumerated in the UDHR, and in order to hold states accountable for the protection of those rights, the UN promulgated the International Covenant on Civil and Political Rights (ICCPR)[83] and the ICESCR in

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81. *Id.* at art. 25(1). The original draft of Article 25 stated that "[e]veryone, without distinction as to economic and social conditions, has the right to the preservation of his health" through the appropriate standard of food, clothing, housing, and medical care. During the drafting of the UDHR, the emphasis of this article changed from a primary focus on the right to health to its current formulation. *See* UNITED NATIONS YEARBOOK (Lake Success, N.Y. 1948).

Other rights set forth in the UDHR, all of which are to be respected without discrimination, include: the right to life, liberty, and security of person; the prohibition of slavery, torture, and cruel, inhuman, or degrading treatment; the right to an effective judicial remedy; the prohibition of arbitrary arrest, detention, and exile; freedom from arbitrary interference with privacy, family, or home; freedom of conscience, religion, expression, and association; freedom of movement; and the right to participate in government. UDHR, *supra* note 74.

82. *See generally* Hurst Hannum, *The Status and Future of the Customary International Law of Human Rights: The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT'L & COMP. L. 287 (1995) (discussing the acceptance of the UDHR as customary international law). Customary international law develops through general and consistent practice of States undertaken from a sense of legal obligation. *See* RESTATEMENT [THIRD] OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102. It is one of the sources of international law.

83. International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976 [hereinafter ICCPR].

1966. These two Covenants, which entered into force in 1976, create a treaty-based structure to promote and protect human rights that is binding on all signatory states. Unlike the UDHR, the Covenants divide human rights into two instruments that separately address civil and political rights and economic, social, and cultural rights.

The ICESCR outlines a fairly broad right to health. Article 12 of the ICESCR requires governments to recognize "the right of everyone to the highest attainable standard of physical and mental health."[84] This articulation of the right to health is much more direct and expansive than its predecessor in the UDHR. The ICESCR provides for a direct right to physical and mental health, compared with the UDHR's more indirect guarantee of a "standard of living" sufficient to achieve health. The ICESCR also sets an ambitious criterion for satisfying the right to health, requiring that states work toward the "highest attainable" standard of health. Article 12 of the ICESCR sets out several steps to be taken to achieve such "full realization" of the right to health, including "[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases" and "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[85] The right to health codified in the ICESCR is binding on the approximately 150 states that have signed and ratified this covenant.[86] States that have not ratified the ICESCR, including the United States, may also be bound by its enumerated rights through the operation of customary international law.[87]

The ICESCR strengthened the right to health by providing an enforcement mechanism. The UN Committee on Economic, Social, and Cultural Rights (CESCR) evaluates country reports on human rights compliance and adopts what are known as "general comments" and "concluding observations" based upon these reports. It should be noted, however, that individuals do not have authority to bring complaints to

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84. ICESCR, *supra* note 77, at art. 12(1).

85. *Id.* at art. 12(2).

86. As of June 9, 2004, 149 states have ratified the ICESCR. Office of the United Nations High Commissioner on Human Rights, *Status of Ratifications of the Principal International Human Rights Treaties*, *available at* http://www.unhchr.ch/pdf/report.pdf (last visited July 28, 2004) [hereinafter Status of Ratifications].

87. To the extent the right to health is enunciated in the UDHR, it is likely customary international law. For an explanation of customary international law, see Hannum, *supra* note 82.

the CESCR.[88] The CESCR has frequently admonished countries for failing to comply adequately with the right to health and it has required countries to provide updates to the CESCR on remedial steps taken.[89]

The incorporation of the right to health in the UDHR and the ICESCR provided a strong foundation for widespread recognition of the right to health. Nonetheless, the references to a right to health in these instruments, and in subsequently drafted international treaties[90] and regional human rights instruments,[91] did not resolve ongoing questions

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88. The CESCR can use its concluding observations to country reports to compel states to improve their compliance with the right to health. It does not, however, possess any ability to use monetary sanctions to induce states to respond. Their leverage is mainly exercised through political pressure, and their findings may be adopted by courts at the national level. *See* STEINER & ALSTON, *supra* note 46, at 316.

89. See COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, REPORT ON THE TWENTY-EIGHTH AND TWENTY-NINTH SESSIONS, E/2003/22, E/C.12/2002/13 (2002) (finding several countries in violation of the right to health and recommending steps for these countries to take to come into compliance).

90. Many international human rights instruments have incorporated variations of the right to health into their respective texts. The International Convention on the Elimination of All Forms of Racial Discrimination (CERD) recognizes "the right to public health, medical care, social security and social services." International Convention on the Elimination of All Forms of Racial Discrimination, Dec. 21, 1965, art. 5(e)(iv), G.A. Res. 2106 A(XX), 660 U.N.T.S. 195 (1969) [hereinafter CERD]. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) includes a "right to protection of health and to safety in working conditions" and calls for the elimination of "discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services." Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, arts. 11, 12, 1249 U.N.T.S. 13, *entered into force* Sept. 3, 1981 [hereinafter CEDAW]. The Convention on the Rights of the Child (CRC) codifies "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." Art. 24, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/736 (1989) [hereinafter CRC]. Furthermore, each of these conventions creates oversight bodies to monitor adherence to these rights.

91. Regional instruments contain right to health provisions that more specifically and descriptively outline member states' obligations. The right to health under the European Social Charter expressly encompasses public health and health care. European Social Charter, Oct. 18, 1961, art. 11, 529 U.N.T.S. 89 (1965) (stating that the state has a duty to "remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases as well as accidents").

The Inter-American System's Protocol of San Salvador advances a similarly descriptive and expansive conception of the right to health. It calls for "enjoyment of the highest level of physical, mental and social well-being" and offers six specific subject areas that comprise the right to health including "satisfaction of the health needs of the highest risk groups." Additional Protocol to the American Convention on Human Rights in the Area of

about the scope and definition of the right.[92] Early conceptions of the right to health often failed to provide substantial context or explanation to articulate the contours of the right. One of the most detailed conceptualizations of the right to health was the World Health Organization's (WHO) Declaration of Alma Ata, which states:

> [H]ealth, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right . . . . [T]he attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.[93]

In the year 2000, the CESCR released General Comment 14 to clarify the right to health under the ICESCR.[94] Entitled "The Right to the

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Economic, Social and Cultural Rights (Protocol of San Salvador), adopted Nov. 17, 1988, art. 10, O.A.S. Treaty Series 69. As stated in the Protocol, states must make efforts to ensure:

> primary care, that is, essential health care made available to all individuals and families in the community; extension of the benefits of health services to all individuals subject to the State's jurisdiction; universal immunization against the principal infectious diseases; prevention and treatment of endemic, occupational and other diseases; education of the population on the prevention and treatment of health problems; and satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

Id.

The African Charter on Human and Peoples' Rights incorporates "the right to enjoy the best attainable state of physical and mental health" and requires member states to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." African Charter , *supra* note 76, at art. 16.

92. *See e.g.*, LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997) (explaining the lack of precise standards and definitions for the right to health); HEALTH AND HUMAN RIGHTS: A READER (Jonathan M. Mann et al. ed. 1999); TOEBES, *supra* note 75, at 243-288 (delineating complications with defining the content of the right to health); Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457 (2001) (discussing the scope of the definition of the right to health); Stephen D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1 (1994) (exploring different definitions for an international right to health); DAVID P. FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS OF GLOBAL HEALTH JURISPRUDENCE 302-09 (2000) (examining the scope of the right to health under international law).

93. Declaration adopted by the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (emphasis added). The WHO is a part of the UN system, but does not operate under the explicit authority of the aforementioned human rights instruments.

94. Committee on Economic, Social and Cultural Rights, The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter General Comment 14]. General Comments explain and interpret provisions in instruments such as the ICESCR

Highest Attainable Standard of Health," the Comment sets out the most authoritative and comprehensive interpretation of the right to health to date.[95] General Comment 14 formulates a broadly conceived right to health that is so intertwined with other rights as to make the right to health "indispensable" to the exercise of those rights.[96] According to the General Comment, the right to health applies to conditions and actions that affect health directly and encompasses the underlying conditions that indirectly influence human health, such as adequate nutrition, housing, drinking water that is free of contamination, safe workplaces, sanitation, and a healthy environment.[97]

Importantly, the right to health does not guarantee the right to be healthy.[98] Rather, General Comment 14 outlines both "freedoms and entitlements" that emanate from the right itself. The freedoms cited are grounded in the context of personal autonomy. They include sexual and reproductive freedom, the right to control over one's health and body, and freedom from interference, including the right to be free from torture and from "non-consensual medical treatment or experimentation."[99] Alternatively, entitlements stem from a more affirmative conception of rights. They encompass the right to a health system that broadly protects health through the provision of both health care and public health services, while providing "equality of opportunity . . . to enjoy the highest attainable level of health."[100]

General Comment 14 divides the normative content of the right to health into four substantive criteria that apply to health facilities, goods, and services. These are availability, accessibility, acceptability, and quality.[101] *Availability* requires the government to offer a sufficient quantity of facilities, goods, and services, including "underlying determinants of health," such as safe and potable drinking water, sanitation,

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and the ICCPR but are not binding law. General Comment 14 is meant to explicate Article 12 of the ICESCR. The normative standards outlined by the Comment have been used by the CESCR to find states in non-compliance with the right to health. *See* discussion, *supra* notes 88-89.

95. *See* Lawrence O. Gostin, *The Right to Health: A Right to the "Highest Attainable Standard of Health,"* 31 HASTINGS CENTER REPORT 29 (March/April 2001).

96. General Comment 14, *supra* note 94, ¶ 1.

97. *Id.* ¶ 11.

98. *Id.* ¶ 8.

99. *Id.*

100. *Id.*

101. *See* Gostin, *The Right to Health*, *supra* note 95, at 29-30.

functional health services, trained health care professionals, adequate health treatment facilities, and essential medicines.[102] *Accessibility* conveys an obligation requiring that health facilities, goods, and services to be within reach of the entire population and that access thereto be free of discrimination or economic, geographic, physical, or informational barriers.[103] The norm of *acceptability* demands that health services conform to standards of medical ethics and respect cultural mores.[104] Health services are required to meet high standards of *quality* based on criteria that are scientifically and medically appropriate.[105]

The state's obligations under the right to health are threefold: to respect, to protect, and to fulfill.[106] The obligation to *respect* prohibits a State from interfering directly or indirectly with its citizens' enjoyment of the right to health.[107] For example, the State must not limit equal access to health services, impede traditional preventive care and medical practices, market unsafe drugs, or engage in deleterious environmental practices.[108] The responsibility to *protect* mandates that the State take affirmative measures to guarantee that third parties, including private parties and businesses, do not interfere with the right to health.[109] The duty to *fulfill* obligates the State to take appropriate affirmative measures to facilitate and promote the right to health and to provide the means to enable individuals or groups to enjoy the right to health fully.[110]

Violations of the right to health may occur through State actions or omissions.[111] A violation through State action occurs when government

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102. General Comment 14, *supra* note 94, ¶ 12(a).
103. *Id.* ¶ 12(b).
104. *Id.* ¶ 12(c).
105. *Id.* ¶ 12(d).
106. *Id.* ¶ 33.
107. *Id.*
108. *Id.* ¶ 34.
109. *Id.* ¶ 35.
110. *Id.* ¶ 33. Appropriate measures may be legislative, administrative, budgetary, judicial, or promotional in nature. *See id.* A number of core obligations are cited as vital to ensuring a minimal level of services: nondiscriminatory access to services; safe and adequate food; potable water; basic shelter and sanitation; essential drugs; reproductive and maternal services; immunization; infectious disease control; access to health information; and training of health personnel. *See id.* ¶¶ 43-45.
111. *See id.* ¶¶ 48-49. General Comment 14 does not itself provide for enforcement of violations of the right to health. Signatory states may be found in violation by the CESCR. *See* discussion, *supra* notes 88-89.

policies actively deny access to health services, create negative health effects on the population, or otherwise disregard the human rights standards of the sort outlined in General Comment 14.[112] By contrast, a violation by omission occurs when a State fails to take appropriate steps to realize the right to health in a progressive manner.[113] However, a State that is willing to comply with the General Comment 14 standards but lacks the immediate resources to do so will not be considered in violation.[114]

General Comment 14 proposes detailed implementation standards. These standards require states to formulate and enact framework legislation establishing a national strategy to respect and promote the right to health. The State must dedicate economic and logistical resources to implementation of this strategy, evaluate their progress through goals and benchmarks, and establish appropriate procedures to enforce remedies and accountability for violations of the right to health.[115]

The 2002 appointment of a Special Rapporteur on Health by the UN Commission on Human Rights represented another significant development in the evolution of the right to health in the UN system.[116] The Special Rapporteur, Paul Hunt, has a mandate to clarify further the contours and content of the right to health; to promote, and encourage others to promote, the right to health as a fundamental human right; and to identify good practices for implementation of the right to health at the community, national, and international levels.[117]

General Comment 14 and the establishment of a Special Rapporteur on Health have significantly elucidated the right to health in the

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112. *See* General Comment 14, *supra* note 94, ¶ 48.

113. *See id.* ¶ 49.

114. *Id.* ¶ 47; *see also*, STEINER & ALSTON, *supra* note 46, at 287-98 (discussing the relevance of resource constraints on implementation of the ICESCR).

115. General Comment 14, *supra* note 94 ¶¶ 53-58.

116. UN Commission on Human Rights, The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Commission on Human Rights Resolution 2002/31 (April 22, 2002). Paul Hunt (New Zealand) was appointed in August 2002 for a three-year term.

117. Paul Hunt, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health , Report of the Special Rapporteur, Commission on Human Rights*, 59th Sess, UN Doc. E/CN.4/2003/58 (2003); *see also*, Paul Hunt, *The UN Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions*, 7 HEALTH & HUM. RTS. 1 (2003) (expounding upon the activities of the Special Rapporteur on Health).

international context. These developments will lead to a more robust conception of the right to health and a more uniform acceptance of this conception. The growing recognition of the importance of the right to health, in conjunction with the consistent inclusion of the right to health in other international,[118] regional,[119] and national[120] instruments, has clarified the right and increased its enforceability.

2. *Limitations on the Right*

Despite the inclusion of the right to health in multiple international documents and the development of more comprehensive explications of the right to health, violations of the right to health continue to occur. Impediments to the enforceability of the right to health may stem from several factors: 1) the varying applicability of the ICESCR (including General Comment 14) to ratifying and non-ratifying states; 2) the structural limitations associated with economic, social, and cultural rights within the ICESCR; 3) the lack of substantial jurisprudential development in the international or regional human rights systems; and 4) political and societal factors that may hinder full implementation.

The first limitation on enforceability arises out of problems associated with the applicability of the ICESCR. All states that have ratified the ICESCR are required to take into consideration the conditions associated with the right to health described in General Comment 14 as they implement that right. The ICESCR, however, has not been universally ratified.[121] Notably, the United States has yet to accede to its provisions. Countries that have not ratified the ICESCR are not subject to the direct enforcement procedures of the CESCR. Nonetheless, non-ratifying countries are subject to customary international law, which is widely considered to incorporate the UDHR. Additionally, non-ratifying countries may still be persuaded on political and moral grounds to recognize the right to health as it is articulated in Article 12 and General Comment 14. Countries may also be bound to uphold the right to health

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118. *See* discussion, *supra* note 90.

119. *See* discussion, *supra* note 91.

120. According to the first report issued by the Special Rapporteur on Health, over 60 national constitutional provisions incorporate the right to health or the right to health care. *See* Hunt, Report of the Special Rapporteur, *supra* note 117.

121. Status of Ratifications, *supra* note 86.

based upon their ratification of other regional and international instruments that include this right.[122]

The right to health under the ICESCR is subject to "progressive realization," meaning that States do not have to comply immediately with all of the aspects of the right to health.[123] Rather, governments have an obligation to take appropriate steps towards full realization of the highest attainable standard of health, to develop a national health policy, and to enforce relevant laws as soon as the Covenant is ratified.[124] Failure to take immediate actions to further the right to health may be a violation of Article 12. State actions must be "deliberate, concrete and targeted towards the full realization of the right to health."[125]

The dearth of legal precedent related to the right to health in national and international fora is another possible reason for the limited enforcement of the right to health in the international arena thus far. This could, however, prove to be either as an asset or a limitation to the future interpretation and enforcement of the right.[126] The lack of extensive case law in this area means that many national courts and some regional human rights bodies will be determining the scope of the right to health with little, if any, precedent upon which to draw. The

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122. *See* discussion, *supra* notes 90 and 91.

123. *See* General Comment 14, *supra* note 94, ¶ 56. Rights under the ICESCR may be limited as "determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society." ICESCR, *supra* note 77, at art. 4. When the drafters of the ICESCR wanted to impose a more specific limitation on an enumerated right, the limitation was included within the article addressing that right. The right to health has no such specific limitation. Therefore, the right to health is only limited by the "general welfare" limitation found in article 4, which is applicable to all economic, social, and cultural rights under the Covenant. For a further discussion on treaty interpretation, *see infra* notes 186-188 and accompanying text.

124. *See* .General Comment 14, *supra* note 94, ¶49.

125. *Id.* ¶30.

126. Court decisions in the regional human rights systems have been rare in the context of the right to health. Regional human rights litigation invoking the right to health has typically occurred within the context of a broader complaint asserting violations of multiple rights. One exception to this rule is a 1985 case before the Inter-American Commission in which the Commission found a violation of the right to health under Article XI of the American Declaration of Human Rights. *See* Case 7615, Inter-Am. C.H.R. 24, OEA/ser. L./V./11.66, doc. 10 rev. 1 (1985) (finding that building projects undertaken by the Brazilian government through the lands of the Yanomami Indian Tribe, which forced them to abandon their homes, violated their right to health and well-being under Article XI of the American Declaration of Human Rights).

promulgation of General Comment 14, however, presents an opportunity for these courts to adopt an interpretation of the right to health consistent with its holistic conception. It is likewise possible that the annual reports of the Special Rapporteur on health will influence the interpretation of the scope of the right to health.

Finally, political factors, resource constraints, and other societal forces may have the practical effect of constraining the enforceability of the right to health. Even the holistic right to health envisioned by General Comment 14 does not guarantee an absolute "right to be healthy."[127] Regardless of how effectively the right to health is implemented, the attainment of good health depends on multiple determinants, which include a State's political will to implement the right to health, satisfy biological and socio-economic preconditions, and guarantee the availability of often-scarce government resources.[128]

In summary, full implementation of the right to health may be impeded under certain circumstances. Importantly, furtherance of the right to free exercise of religion is not one of those circumstances. Despite the aforementioned practical constraints on the full realization of the right to health, the right is not limited in any formal way under international human rights law. Codifications of the right do not contain any textual limitations, including limitations by the right to religion.

The right to health is well established, and its scope and applicability continue to develop. The principles established under the right to health should be respected by all nations as fundamental to human rights due to their importance to human dignity and well-being and their place in international law. The right to health is fundamental because it in some ways presages the achievement of other human rights.[129] For example, a minimal level of health is necessary to practice religion. The following section discusses the right to religion under international law.

B. The Right to Freedom of Thought, Conscience, and Religion

The right to freedom of thought, conscience, and religion has a long history due to the centrality of religious practices to people's lives.

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127. *See* General Comment 14, *supra* note 94, ¶¶ 8-9.

128. *Id.*

129. *See* Lawrence O. Gostin, *Beyond Moral Claims: A Human Rights Approach in Mental Health*, 10 CAMBRIDGE QUART. OF HEALTH CARE ETHICS 264 (2001).

After World War II, the right was enshrined in international agreements and declarations, securing its place as an internationally recognized human right. It is also accepted that the right is subject to certain limitations. Notably, one acceptable basis for limiting the right to religion is the protection of public health.

1. *Exploring the Right*

The protection of religious freedom is one of the earliest recognized fundamental rights.[130] Seventeenth-century treaties contained a number of clauses protective of religious expression, while national law began to incorporate notions of religious tolerance over four hundred years ago.[131] The idea of religious tolerance eventually evolved from the toleration of only certain religions to the recognition of a broader right to religion and belief.[132] For example, the 1874 federal constitution of Switzerland established full freedom of faith and conscience,[133] and the First Amendment to the U.S. Constitution (ratified in 1791) enshrined the freedom of religion as a basic tenet of individual liberty in the United States.[134] At the international level, the UDHR recognized the right to religion in Article 18:

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.[135]

The UDHR does not define religion or belief expressly. In fact, modern human rights law in general has shied away from defining these

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130. Natan Lerner, *Religious Human Rights Under the United Nations*, *in* RELIGIOUS HUMAN RIGHTS IN GLOBAL PERSPECTIVE: LEGAL PERSPECTIVES 83 (Johan D. vand der Vyver & John Witte, Jr., eds.).

131. *Id.* at 84.

132. ARCOT KRISHNASWAMI, STUDY OF DISCRIMINATION IN THE MATTER OF RELIGIOUS RIGHTS AND PRACTICES, UN Doc. E/CN.4/Sub.2/200/Rev.1, UN Sales No. 60.XIV.2 (1960), *available at* http://www.religlaw.org/interdocs/ docs/akstudy1960.htm [hereinafter Krishnaswami Study].

133. *Id.* at 4.

134. U.S. Const. amend. I ("Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . ..").

135. UDHR, *supra* note 74, at art. 18.

terms.[136] To avoid complicated philosophical debates, the use of the terms "religion" and "belief," taken together, was meant to encompass theistic, atheistic, agnostic, and rationalistic conceptions of the universe and codes of behavior.[137] Freedom of thought incorporated philosophical and scientific concepts that were not "religious" in nature.[138] While a broad conceptualization of the terms offers protection for those that follow a particular religion, as well as those that choose to follow no religion, it is emblematic of the complexity of this area that even basic terms remain undefined.

The ICCPR also elaborates upon the right to religion:

> 1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
> 2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
> . . .
> 4. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.[139]

The terms of the ICCPR are similar to those of the UDHR in that freedom of thought, conscience, religion, and belief are protected. While other treaties protect certain religious freedoms or groups,[140] Article 18 of the ICCPR constitutes the primary global provision governing the right to religion due both to its breadth and the fact that the ICCPR is the only global human rights treaty that deals with religion while also incorporating enforcement mechanisms.[141]

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136. Gunn, *supra* note 3, at 190 (noting that "[a]lthough many international and regional human rights instruments guarantee rights related to freedom of religion or belief, none attempt to define the term 'religion'").

137. Lerner, *supra* note 130, at 82.

138. Malcolm D. Evans, *The United Nations and Freedom of Religion: The Work of the Human Rights Committee*, *in* LAW AND RELIGION 40 (2000).

139. ICCPR, *supra* note 83, at art. 18. Section 3 deals with limitations, discussed below.

140. *See, e.g.*, Convention on the Prevention and Punishment of the Crime of Genocide, Dec. 9, 1948, art. II, 78 U.N.T.S. 277 (entered into force Jan. 12, 1951); CERD, *supra* note 90, at art. 5; ICESCR, *supra* note 77, at arts. 2, 13.

141. Lerner, *supra* note 130, at 98.

The right as enunciated in the ICCPR encompasses the adoption of a religion or belief, including the right to be free from coercion, in this context. The right is envisioned as being practiced either alone or in community, which is notable because of the individual focus of many of the other rights in the covenant. Under the covenant, one has the freedom to manifest one's beliefs through worship, observance, practice and teaching. Finally, the role of the parent or guardian in controlling the religious and moral education of the child is recognized.

In 1981, the UN General Assembly adopted the Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (Declaration), reaffirming the right to freedom of thought, conscience, religion, and belief while emphatically prohibiting discrimination based on religion or belief.[142] The Declaration states that such discrimination "constitutes an affront to human dignity and a disavowal of the principles of the Charter of the United Nations, and shall be condemned as a violation of the human rights and fundamental freedoms . . . ."[143] Article 6 of the Declaration includes the following rights as protected under freedom of thought, conscience, religion, or belief: to worship or assemble and maintain places for these purposes; to establish charitable institutions; to make, acquire, and use the articles and materials related to the rites or customs of a religion or belief; to write and disseminate publications; to teach in suitable places; to solicit voluntary financial contributions; to train and designate leaders called for in the religion or belief; and to observe days of rest, holidays, and ceremonies.[144] This list, in conjunction with the rights set forth in Article 1 of the Declaration (which is substantially similar to Article 18 of the ICCPR), can be taken as a universally agreed-upon minimum standard for determining the scope and content of the right to religion.[145]

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142. *Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief,* G.A. Res. 36/55, U.N. GAOR, 36th Sess., at 171, U.N. Doc. A/RES/36/55 (1981), *available at* http://www.un.org/Depts/dhl/resguide/resins.htm. It is worth mentioning that a draft treaty on the same subject was considered at the UN, but its development has been placed on hold. Evans, *supra* note 138, at 36.

143. *Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief, supra* note 142.

144. *Id.* at 172.

145. Lerner, *supra* note 130, at 117.

2. *Limitations on the Right*

While the right to freedom of thought, conscience, and religion is well established, it is also recognized that the right is not absolute. International treaties contain explicit limitations on the right. Given that a conflict between the right to health and the right to religion would likely be resolved by determining the limits on the right to religion, they are worth considering here.

As discussed above, any limitation on the rights set forth in the UDHR must be determined by law, for the purpose of securing the rights of others, or meeting the just requirements of morality, public order, or the general welfare.[146] The limitations clause on the right to religion in the ICCPR is specific to Article 18. Section 3 of that Article states: "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."[147] Accordingly, to be in compliance with the covenant, a limitation on the right to religion must be prescribed by law and must be necessary to protect one of the listed goals.[148]

A number of sources have addressed the scope of allowable limitations on the right to religion. Foremost among these are the UN-commissioned report of the Special Rapporteur, Arcot Krishnaswami,[149]

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146. UDHR, *supra* note 74, at art. 29.

147. ICCPR, *supra* note 83, at art. 18, ¶ 3.

148. It is interesting to note that national security is not one of the legitimate bases for restricting the right to religion outlined in the covenant. Lerner, *supra* note 130, at 92. *Accord* United Nations Human Rights Committee General Comment 22, Article 18, 48th Sess., at 35, U.N. Doc. HRI/GEN/1/Rev.1 (1994) [hereinafter General Comment 22] (stating that "paragraph 3 of article 18 is to be strictly interpreted: restrictions are not allowed on grounds not specified there, even if they would be allowed as restrictions to other rights protected in the Covenant, such as national security."). *But see* Krishnaswami Study, *supra* note 132, at 21 ("Nor can public authorities allow activities aimed at the destruction of the State, such as rebellion or subversion, even though undertaken in the name of religion or belief. They are always entitled to restrain or to limit such activities provided that they act in good faith to preserve the security of the State and do not employ the restraints or limitations as a pretext for justifying a policy of repression of faith."). The Krishnaswami view seems to be accepted by the European Court of Human Rights under Article 9 of the European Convention on Human Rights, which is substantially similar to the text of Art. 18 of the ICCPR. *See* Refah Partisi v. Turkey, 37 E.H.R.R. 1 (2003).

149. Krishnaswami Study, *supra* note 132.

the Human Rights Committee's General Comment 22 on the subject,[150] and the jurisprudence of the Human Rights Committee.[151] Each of these has elaborated upon the concept of acceptable limitations on the right to religion.

In 1956, the UN Sub-Commission on the Prevention of Discrimination of Minorities appointed Arcot Krishnaswami as a Special Rapporteur to produce a study on religious human rights that would include a consideration of strategies for eradicating religious discrimination.[152] Rapporteur Krishnaswami submitted his report in 1960.[153] The report has greatly influenced the development of understanding on the right to religion, and it ultimately became the basis for the first draft of the UDHR.[154]

In Krishnaswami's view, the task of identifying allowable limitations on the right to religion cannot be pursued in the abstract.[155] He observed that a variety of interpretations can be given to the limitation provision in the UDHR,[156] concluding that "[a]ll that can be affirmed is that the criteria laid down are intended to exercise a check on arbitrary judgment."[157] Further complicating the issue in his opinion was the fact that "morality, public order and general welfare are not immutable concepts."[158] However, Krishnaswami believed that certain manifestations were "so obviously contrary to morality, public order, or the gen-

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150. Human Rights Committee, *The Right to Freedom of Thought, Conscience and Religion (Art. 18): CCPR General Comment 22*, July 30, 1993. The Human Rights Committee (HRC) is the body created by the ICCPR charged with enforcement of the convention. The HRC is comprised of 18 independent experts elected by the states parties. The Committee considers the periodic reports of states parties as well as communications brought by individuals under the First Optional Protocol to the Convention.

151. The European Court of Human Rights has also interpreted the right to religion under the European Convention on Human Rights. *See* Javier Martinez-Torron, *Religious Liberty in European Jurisprudence*, *in* RELIGIOUS LIBERTY AND HUMAN RIGHTS 99-127 (Mark Hill ed., 2002); T. Jeremy Gunn, *Adjudicating Rights of Conscience Under the European Convention on Human Rights*, *in* RELIGIOUS HUMAN RIGHTS IN GLOBAL PERSPECTIVE: LEGAL PERSPECTIVE 305-330 (Johan D. van der Vyer & John Witte, Jr. eds., 1996).

152. *See* Lerner, *supra* note 130, at 100.

153. Krishnaswami Study, *supra* note 132.

154. Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief, *supra* note 142; Lerner, *supra* note 130, at 119.

155. Krishnaswami Study, *supra* note 132, at 20.

156. At the time of Krishnaswami's report, the ICCPR had not yet been drafted.

157. *Id.*

158. *Id.* at 21.

eral welfare" that public authorities had broad power to limit them.[159] Among these were practices such as human sacrifice, self-immolation, mutilation of the self or others, and slavery or prostitution if carried out because of a religion or belief.[160]

In terms of protecting the public's health, the study indicated that regulation by public officials of burial, cremation, or other means of disposing of the dead was a legitimate exercise of state power.[161] In addition, where an epidemic disease threatens the community, public authorities have an obligation to take preventative measures in the interests of the entire population and "*cannot* therefore exempt the members of any particular faith from the operation of these measures."[162] This supports the notion that a government can insist upon scientifically proven methods for curing and preventing disease, and that it can thereby overrule the prescriptions of an individual's religion or belief.[163]

Krishnaswami's study marked an important step toward defining the parameters for determining when it is proper for the state to restrict religious rights in the interest of protecting certain social goods. In Krishnaswami's view, the power to restrict religious practice to protect the public health was quite broad. This view was developed within the context of the UDHR, since the ICCPR had not yet been drafted.

The advent of the ICCPR provided an opportunity for further development. As the enforcement body of the ICCPR, the UN Human Rights Committee (HRC) provided, in its General Comments, guidance on the power of governments to restrict the expression of religion. The HRC's General Comment 22 on the right to freedom of thought, conscience, and religion offered important observations on the nature of the right to religion, as well as on the limitations of that right that are

159. *Id.* at 20.

160. *Id.*

161. *Id.* at 24.

162. *Id.* at 33 (emphasis added).

163. Controversially, the study posited that public officials are entitled to intervene in situations in which an individual refuses scientific medical treatment when his life is in jeopardy. Krishnaswami reasoned that such interventions are similar to state interventions to prevent suicide. *Id.*

acceptable under the ICCPR.[164] The Comment first notes that the rights protected in Article 18 are "far-reaching and profound," and that the rights cannot be derogated from, even in times of public emergency.[165] Importantly, however, the Comment also observes that the covenant makes a distinction between freedom of thought, conscience, religion, and belief on the one hand, and freedom to *manifest* religion or belief on the other hand.[166] The "internal" freedoms of thought, conscience, religion, and belief are protected unconditionally and cannot be subjected to any limitations.[167] However, the Comment notes, Article 18.3 permits restrictions on the external manifestations of religion or belief.[168]

In the HRC's opinion, manifestations of religion or belief include ritual and ceremonial acts, use of ritual formulae and objects, observance of holidays and days of rest, and customs, such as the observance of dietary regulations, wearing distinctive clothing, participating in rituals marking the stages of life, and the use of a particular language.[169] As for limiting such manifestations, the Committee made several useful observations. Generally, "in interpreting the scope of permissible limitation clauses, State parties should proceed from the need to protect the rights guaranteed under the Covenant, including the right to equality and nondiscrimination."[170] Thus, limitations imposed on the right to religion should serve to guard other human rights.

The Committee outlined four additional principles useful to determining the appropriateness of a limitation on the right to religion. First, the limitation must be established by law.[171] Second, the limitation must be applied for only those reasons listed in Article 18, and it must be "directly related and proportional to the specific need on which [it is]

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164. General Comments provide one of the most important sources of interpretation of the ICCPR. Evans, *supra* note 138, at 38.

165. General Comment 22, *supra* note 148, ¶ 2.

166. *Id.*

167. *Id.*

168. *Id.* ¶ 8. The jurisprudence of the European Court of Human Rights reflects a similar separation of the internal and external aspects of religious liberty. Javier Martinez-Torron, *Religious Liberty in European Jurisprudence*, in RELIGIOUS LIBERTY AND HUMAN RIGHTS 117 (Mark Hill ed., 2002).

169. General Comment 22, *supra* note 148, ¶ 4.

170. *Id.* ¶ 8.

171. *Id.*

predicated."[172] Third, a limitation cannot be imposed for the purposes of discrimination, or applied in a discriminatory manner.[173] Finally, the Committee elaborated on the notion that the right to manifest a religious belief may be limited for the purposes of protecting public morals. After noting that the concepts of morality are based on various social, philosophical, and religious traditions, the Committee opined that moral restrictions "must be based on principles not deriving exclusively from a single tradition."[174]

Finally, the jurisprudence of the HRC further refines the analysis of limitations on religious manifestations by developing a reasonableness standard. In addressing individual complaints under the First Optional Protocol to the ICCPR,[175] the HRC has given states ample leeway to impose restrictions on religion.[176] For example, in *K Singh Bhinder v. Canada*, the Committee found that requiring an employee to wear a hard-hat was a justifiable limitation under Article 18.[177] The complainant, a Sikh who wore a turban, argued that any risk he was undertaking was his own.[178] The Committee disagreed and found the hard-hat requirement reasonable.[179]

There are many difficulties inherent in defining the legal right to religion. Defining the situations or conditions under which a government may impose limitations on that right is perhaps even more complicated. Nonetheless, there seems to be general agreement with the notion that governmental restrictions on the right to religion that are based on the protection of the public's health are generally acceptable and consistent with the rights enshrined in international law.

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172. *Id.*

173. *Id.*

174. *Id.*

175. ICCPR, *supra* note 83. The First Optional Protocol to the ICCPR allows individuals to submit complaints against governments that are signatories to the Protocol to the Human Rights Committee. The Committee then makes findings regarding the complaint, which the government is expected to respect.

176. Evans, *supra* note 138, at 50.

177. Karmel Singh Bhinder v. Canada, Human Rights Committee, Communication No. 208/1986: Canada, Nov. 28, 1989, UN Doc. CCPR/C/37/D/208/1986.

178. *Id.*

179. The Committee did not elaborate upon the reasoning behind its finding. *See id.* In the European system, governmental restrictions on the right to religion based on improving public health have similarly been upheld. *See, e.g.*, X v. UK, The Jewish Liturgical Association Ch'are Shalom ve Tsedek v. France, 27 June 2000.

III. BALANCING CONFLICTS BETWEEN THE RIGHTS TO HEALTH AND RELIGION

Religion impacts public health in a variety of ways. In some cases, religious prescriptions can influence the policymaking of public health authorities and other governmental officials. In other situations, individual religious practices may effect the public's health directly. Since the right to health and the right to religion are both protected by human rights law, what happens when the two conflict? While it is a difficult question to answer, we argue that international law supports the grounding of policies on scientific rather than religious principles when the rights to religion and health conflict.[180]

Government officials charged with public health policymaking are forced to make difficult decisions when they are faced with religious practices that conflict with public health concerns. These officials have a legal obligation to promulgate laws and policies that are consistent with and protective of human rights. This duty requires careful consideration of the effects of government policies on the religious practices of individuals. In some countries, religious institutions have close connections with government.[181] In countries where the two are not as intertwined, religious groups may nevertheless influence policy through the democratic process as well as through lobbying.

While it is true that religious beliefs and practices can lead to positive public health results, governments should resist religious influence over health policy when such practices have negative health consequences. This is true for three reasons. First, international law recognizes inherent limitations on the right to manifest religion in order to protect or promote public health. Second, basing health policy on religion instead of scientifically proven interventions may directly interfere with the realization of the right to health. Third, health policies based on

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180. The authors would like to emphasize that the discussion here is aimed entirely at the problems that arise when the right to religion presents a conflict with the right to health. To be sure, where the rights do not conflict, the right to manifest religious beliefs should not be restricted.

181. Some governments even recognize a state religion. *See e.g.*, Israeli Declaration of Independence (1948) (stating that Israel is a Jewish state); ISLAMIC REPUBLIC OF IRAN CONST., art. 1-2 (1979) (stating that Iran is an Islamic republic); KINGDOM OF SAUDI ARABIA CONST., art. 1 (stating that Saudi Arabia is a "sovereign Arab Islamic state with Islam as its religion").

religion may have a detrimental impact on other important human rights.

Under international law, public health is recognized as an allowable basis for limiting the right to religion.[182] Article 18.3 of the ICCPR expressly states that "[f]reedom to manifest one's religion . . . may be subject . . . to such limitations as are . . . necessary to protect public . . . health."[183] Therefore, it is consistent with human rights law to take steps that favor the protection of public health over religious practices that conflict with public health demands. In order for a limitation to be acceptable under international law, it must follow the guidelines articulated in the ICCPR's General Comment 22. That is, the limitation should be 1) established by law; 2) directly related and proportional to the goal of public health; and 3) nondiscriminatory.[184]

Each of these guidelines helps to ensure that infringements upon the right to religion promulgated on the basis of public health are not taken pursuant to arbitrary rationales. The first of the guidelines, requiring limitations on manifestations of religious precepts to be established by law, prevents *ad hoc* discrimination against minority religions and guarantees that proper societal attention, through the democratic process, is given to the limitation and its effects. The second guideline, holding that restrictions on religious practice related to health must be proportional to the need, allows a state to restrict the manifestation of religion only to the extent that such restriction is well-tailored to the ends sought. Public health cannot be used lawfully as a means to unnecessarily encumber religious practices. The third guideline ensures that public health measures are enforced in a nondiscriminatory manner. Public health interventions that are intended to discriminate against particular religions are prohibited by a multitude of international conventions that proscribe discrimination.[185] It is important to note that the internal manifestations of a belief (i.e., thoughts) do not interfere with the public's health and no limitations on this aspect of religious observance is therefore permitted under international law. Governments

182. ICCPR, *supra* note 83, at art. 18.3; *see also* text accompanying notes 147-148.

183. *See* ICCPR, *supra* note 83, at art. 18.3.

184. *See* text accompanying notes 171-174, *supra*.

185. *See, e.g.*, ICCPR, *supra* note 83, at arts. 4.1, 20.2; ICESCR, *supra* note 77, at art. 2.2; CERD, *supra* note 90, at art. 5(d)(vii); CRC, *supra* note 90, at arts. 2(1), 14(1), 14(3).

should, consistent with these principles, constrain the impact of religion on public health policy where necessary.

It is also noteworthy that the right to health does not contain the textual limitations explicitly incorporated into the right to religion and several of the other rights enunciated in the two covenants.[186] Under the principle *expressio unius est exlusio alterius*,[187] drafters expressing limitations in certain articles are presumed to have intentionally excluded them in articles where they are not contained.[188] The fact that the right to health does not contain limitations is significant because the drafters demonstrated by their inclusion of such limitations in other articles that they could have so limited the right if they felt such limitation was appropriate. This difference between the right to health and the right to religion indicates that the drafters anticipated the right to religion being limited to protect public health (and therefore the right to health) and not vice versa.

The right to the highest attainable standard of health requires governments to create and maintain conditions that are conducive to the achievement of good health. This necessarily involves respecting the right to health by refraining from the implementation of public health policies that negatively impact health. It also protects the right to health by constraining religious practices that have a harmful effect on the public's health. The state must take affirmative steps to promote health, including such efforts as education campaigns and outreach activities, even if these undertakings conflict with religious practices or beliefs.

Grounding health policy and law on scientifically proven interventions is consistent with human rights. Therefore, states have an obligation to restrict the manifestation of religion where doing so would protect the public health in a significant way. Mandating public health interventions and prohibiting practices that endanger the public's health are both legitimate exercises of state power. For example, if a public health intervention is disfavored by a given religion but is effective in protecting and promoting the public's health, the state should undertake the intervention. Similarly, if religious rites represent a significant

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186. *See, e.g.*, ICESCR, *supra* note 77, at art. 8(1)(a); ICCPR, *supra* note 83, at arts. 12(3), 19(3), 21 and 22.

187. 73 AM. JUR. 2d *Statutes* § 129; J. G. SUTHERLAND, STATUTES AND STATUTORY CONSTRUCTION § 491 (John Lewis ed., 1904).

188. *See, e.g., In re* W.H., 57 P.3d 1 (Kan. 2002).

danger to the public health, they should be outlawed even if doing so interferes with the practice of religion. By basing public health policy on science, the government fulfills its obligations under the public's right to health without violating the internationally recognized right to religion, which is acknowledged as being subject to appropriate limitations.

The fulfillment of other human rights is also supported by grounding government health policy in science. Basing public health policy on religious practices that conflict with scientifically acceptable interventions interferes with a number of valued and enforceable human rights. For example, health policies based on religion may violate the right to education if, where informing the public about an intervention would advance public health, such information is not provided, or worse, if incorrect information is supplied. The right to enjoy the benefits of scientific progress and its applications may also be violated where new treatments are available, or new methods of disease prevention have been discovered, but are kept from the public.[189]

The following examples illustrate the necessity for public policy that gives precedence to scientifically proven interventions over religious practices when the two conflict. Religious prohibitions on condom usage, the advocacy of which is considered by some churches to promote promiscuity, demonstrates a case where strict adherence to religious dogma can have devastating implications for public health. Female genital circumcision, required under some religious beliefs, is an example of a religious rite that brings with it numerous negative health implications. Finally, the potential ramifications of religious exemptions from immunization against communicable diseases make a strong case for the legitimacy of overriding individual beliefs for the benefit of public health.[190] Where a religious institution applies pressure on a government in order to convince it to abdicate proven public health interventions, the cost to the greater public health can be

189. ICESCR, *supra* note 77, at art. 15.

190. Other examples of government policies that are based on religious policies despite evidence that they conflict with the public health include: the current policy of the U.S. administration regarding stem cell research; the current policy of the U.S. administration regarding international funding of family planning (i.e., the global gag rule); and religiously-motivated laws in various countries that fail to criminalize domestic violence and spousal rape and create obstacles to women divorcing men even in situations of abuse.

substantial. For this reason, it is important that states advance the health measures that are most likely to succeed.

A. HIV/AIDS and the Promotion of Condom Usage

Advancement of the right to health requires governments to implement those measures that promote public health while discouraging those that are detrimental to it. Although this is the ideal, it has proven to be politically difficult when powerful religious organizations exert influence over public policy. One example of an area in which scientifically-proven intervention runs into conflict with entrenched religious doctrine involves condom usage, the Catholic Church, and AIDS.

1. *The Risk of AIDS and the Usefulness of Condoms*

Currently, AIDS is the fourth leading cause of death globally;[191] 40 million people are infected.[192] If the current infection trend continues, 100 million people will be infected by 2006.[193] Right now in sub-Saharan Africa, at least 25 million people have AIDS, with an estimated 3,000,000 of those newly infected in 2003.[194] In Latin America, at least 2 million are living with AIDS; of those, 250,000 became infected in 2003.[195]

As the pandemic spreads, the resulting devastation to economic, social, and familial structures becomes more pronounced. Fourteen million children have been left orphaned by the disease, and this number is growing.[196] The disease affects people in their most productive years, destroying productivity and human capital.[197] As more

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191. The Global Fund to Fight AIDS, Tuberculosis and Malaria, *The Global HIV/AIDS Epidemic*, *available at* http://www.theglobalfund.org/en/about/fighting/aids/ (last visited Aug. 4, 2004).

192. UNAIDS, Q&A II: Basic facts about the HIV/AIDS Epidemic and its Impact 11, *available at* http://www.unaids.org/en/resources/questions_answers.asp#II (July 2004) [hereinafter UNAIDS Q&A II].

193. LAWRENCE O. GOSTIN, THE AIDS PANDEMIC: COMPLACENCY, INJUSTICE, AND UNFULFILLED EXPECTATIONS 289 (University of North Carolina Press 2004).

194. UNAIDS Q&A II, *supra* note 192, at 12.

195. *Id.* at 16.

196. Thomas Crampton, *Epidemic Is Attacking the Roots of Society, AIDS: The Global Challenge*, INT'L HERALD TRIB., Dec. 1, 2003, at 10.

197. *Id.* at 28. *See also* GOSTIN, *supra* note 193, at 290.

become ill, there are fewer people to teach children,[198] tend fields, and earn income.[199] Families have greater expenses, including medicine where it is available, and funeral costs. The resultant squeeze on resources may ultimately lead to political destabilization. Stephen Lewis, the UN Secretary-General's special envoy for HIV/AIDS in Africa, has remarked that he "wouldn't discount the possibility, ten or fifteen years down the road, of failed states [as the result of AIDS]."[200]

With the AIDS pandemic continuing to unfold, the world has sought to find effective ways to stem the tide of the disease. One measure proven to combat the transmission of AIDS is condom usage.[201] Scientific evidence has demonstrated unequivocally that condoms can impede the transmission of sexually transmitted infections and the virus that causes AIDS. In 2000, a number of U.S. federal agencies sponsored a workshop to examine the evidence on the effectiveness of latex male condom usage for the prevention of transmission of infection during intercourse.[202] The workshop examined a number of published studies, and issued a summary report. The report concluded that "condoms are highly effective barriers to virus passage with a very small chance of leakage"[203] and that "[i]ntact condoms . . . are essentially impermeable to particles the size of STD pathogens (including the smallest sexually transmitted virus, hepatitis B)."[204] Table A shows the relative risk of exposure to semen with latex condom usage.

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198. UNAIDS Q&A II, *supra* note 192, at 22.

199. *Id.*

200. Stephen Lewis, *The Lack of Funding for HIV/AIDS is Mass Murder by Complacency*, (notes prepared for a press briefing in New York), *available at* http://www.globalpolicy.org/socecon/develop/aids/ 2003/0108murder.htm (Jan. 8, 2003). Secretary of State Colin Powell agrees that the disease is a threat to security: "I was a soldier, but I know of no enemy in war more insidious or vicious than AIDS, an enemy that poses a clear and present danger to the world." Colin Powell, *Quotation of the Day*, N.Y. TIMES, June 26, 2001, at A4.

201. For the purposes of this article, "condoms" refer to latex male condoms.

202. Nat'l Inst. of Allergy and Infectious Diseases, NIH, DHHS; Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention, *available at* http://www.niaid.nih.gov/dmid/stds/condomreport.pdf (July 20, 2001).

203. *Id.* at 7.

204. *Id.*

Condom Use Event	Relative Risk of Exposure to Semen (compared to non-use)
Failure to Use a Condom	1.0
Condom used, but breaks	0.006
Condom used, but has a hole (water leak test)	0.000008
Condom used, no break, no leak	0.0

Source: National Institute of Allergy and Infectious Diseases, NIH, DHHS; Workshop Summary, Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention; 2000, *available at* http://www.niaid.nih.gov/dmid/stds/condomreport .pdf, at 7.

Thus, condoms have been scientifically proven to aid in the prevention of viral infections, including HIV, which spread as a result of sexual activity.[205] Governments that promote condom usage have seen beneficial results. For example, HIV prevalence is receding in Uganda, where government officials promote what is called the "ABC" campaign[206] for "Abstinence, Being faithful, and Condom usage."[207]

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205. *See also* CDC, *How Effective are Latex Condoms in Preventing HIV?*, *available at* http://www.cdc.gov/hiv/pubs/faq/faq23.htm (last updated Dec. 15, 2003).

206. UNAIDS Q&A II, *supra* note 192, at 12.

207. Ken Fireman, *Going Global in AIDS Battle; Bush, Bucking Conservatives, Seeks $15B*, NEWSDAY, April 30, 2003, at A17. There is insufficient information available to "apportion the observed decline between the three factors of abstaining, being faithful to one's partner, and condom use." The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1 to 2005/6 at vi (Mar. 2000), *available at* http://www.unaids.org/html/pub/topics/nsp-library/nsp-africa/nsp_uganda_2000-2006_en_ pdf.htm.

2. *Religiously-based Objections to Condom Promotion and its Effects*

Condom promotion programs, however, have come into direct conflict with the teachings of the Catholic Church. The Church has a long history of prohibiting the use of artificial birth control. This prohibition includes a ban on the use of condoms. In fact, Catholic doctrine eschews the use of condoms for any reason.[208] According to the Catechism of the Catholic Church,[209] "'[E]very action which, whether in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible' is intrinsically evil."[210] Interrupting procreation is considered evil for a number of reasons. It is believed that such actions interfere with God's design for the norm of marriage. The Church also fears that use of artificial birth control would "open wide the way for marital infidelity and a general lowering of moral standards." It is thought to be "an evil thing to make it easy for [people] to break [the moral] law." Finally, the Church fears that birth control may reduce women to being mere instruments for the satisfaction of men.[211]

The Church's proscription against condom usage remains in place even in the face of AIDS. Church guidelines for education within the family state that "parents must also reject the promotion of so-called 'safe sex' or 'safer sex,' a dangerous and immoral policy based on the deluded theory that the condom can provide adequate protection against AIDS."[212] The Catholic Bishops of South Africa, Botswana, and Swaziland have stated that they "regard the widespread and indiscriminate promotion of condoms as an immoral and misguided weapon in our battle against HIV/AIDS" and that "[c]ondoms may even be one

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208. It is important to note that not all Church officials agree with the dictate, and some disregard it and provide advice about condom use. *See* Nicholas D. Kristof, *Don't Tell the Pope*, NEW YORK TIMES, Nov. 26, 2003, at A25. However, the opinions of high Church officials are likely to be the ones most influential to governmental policy makers.

209. *See* CATECHISM, *supra* note 9.

210. *Id.* ¶ 2370.

211. Pope Paul VI, HUMANAE VITAE ¶ 17 (1968).

212. The Pontifical Council for the Family, *The Truth and Meaning of Human Sexuality: Guidelines for Education within the Family* ¶ 139, *available at* http://www.vatican.va/roman_curia/pontifical_councils/family/documents/rc_pc_family_doc_08121995_human-sexuality_en.html (last visited Aug. 4, 2004).

of the main reasons for the spread of HIV/AIDS" because they could be faulty, wrongly used, and contribute to the breakdown of self-control and mutual respect between sexual partners.[213]

More recently, Cardinal Alfonso Lopez Trujillo, President of the Vatican's Pontifical Council for the Family, stated on a BBC program that "[t]he AIDS virus is roughly 450 times smaller than the spermatozoon . . . . The spermatozoon can easily pass through the 'net' that is formed by the condom."[214] He later went on, saying, "I propose that the ministries of health require the inclusion in condom packages and advertisements and in the apparatus or shelves where they are displayed a warning that the condom is not safe."[215] This is in contravention to the scientific understandings regarding condom usage and the positive effect of condom usage on controlling the spread of HIV/AIDS.

Because of the prominence of the Catholic Church, its statements on condom usage have had an effect on the AIDS policy of several nations. In a number of states, the religious prohibition on condom usage has influenced government AIDS prevention policies by weakening the public health message that condoms save lives. The position of the Church has caused governments to condone the spread of misinformation, and in several cases it has caused governments to discuss the effectiveness of condom usage less openly, hampering the effectiveness of a proven public health intervention.

In some instances, the Church has created obstacles to accessing condoms or caused governments to curb pro-condom educational messages. For example, in Kenya,[216] where some priests claimed the contraceptives were "laced with HIV/AIDS," the Church's position led

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213. Archdiocese of Cape Town, *A Message of Hope*, *available at* http://www.catholic-ct.co.za/news/20010730.htm (July 30, 2001). It should be noted that, demonstrating some possible flexibility and non-adherence to the official Church position, the Message also stated that, where one person in a married couple was living with HIV/AIDS and the other was not, the "Church accepts that everyone has the right to defend one's life against mortal danger. This would include using the appropriate means and course of action." *Id.*

214. *Vatican Official Says Condoms do not Protect Against AIDS: "A Recognizable Fact:" Church Makes Same Claim Across Third World, BBC Program Finds*, NATIONAL POST, Oct. 10, 2003, at A11.

215. Bruce Johnston, *Cardinal Wants Health Warnings on "Unreliable" Condoms*, THE DAILY TELEGRAPH (London), Oct. 14, 2003, at 12.

216. Kenya acceded to the International Convention on Economic, Social and Cultural rights on January 3, 1976. Status of Ratifications, *supra* note 86.

an AIDS teaching center to stop distributing condoms.[217] In Peru,[218] the government banned sixteen brands of condoms containing the spermicide nonoxynol-9, warning of the danger[219] but making no effort to explain the risks or recommend other types of condoms.[220] Reportedly, the Minister of Health took these steps as a result of his Catholic beliefs.[221] In Mexico,[222] after the Church criticized First Lady Marta Sahagun for advocating condom use as protection against AIDS, President Fox's political party dropped the word "condom" from its platform for legislative action.[223] In Zambia,[224] health officials withdrew an anti-AIDS campaign that advocated both safe sex and condom use after receiving complaints from the Church that the campaign promoted promiscuity.[225] Thus, it is evident that some leaders are censoring public safety measures in order to conform more closely to the teachings of Church officials.[226] Government officials that base policy on religious

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217. *Vatican Official Says Condoms do not Protect Against AIDS*, *supra* note 215. A member of the Kenyan Parliament reportedly called the Catholic Church "'the greatest impediment in the fight against HIV/AIDS.'" Catholics for a Free Choice, *Catholic Group Refutes Bishops' Claim that Catholic Hierarchy Cannot Ban Condoms*, U.S. NEWSWIRE, January 10, 2002 (citing *Catholic Stand on Disease Criticized*, THE NATION (Kenya), Nov. 29, 1999).

218. Peru ratified the ICESCR on July 28, 1978. *Status of Ratifications*, *supra* note 86, at 8.

219. The WHO reported that this spermicide can damage vaginal walls, which increases the risk of HIV should bodily fluids make contact. However, the WHO concluded that using condoms with the spermicide was still preferable to not using condoms at all. Rebecca Howard, *Birth Control Shift is Criticized in Peru; Health Ministry Focuses on Motherhood*, THE WASHINGTON POST, July 20, 2003, at A21.

220. *Id.*

221. *Id.*

222. Mexico acceded to the ICESCR on June 23, 1981. *Status of Ratifications*, *supra* note 86, at 7.

223. *Mexican Bishops Attack First Lady for Advocating Condom Use Against AIDS*, AGENCE FRANCE-PRESSE, May 9, 2003, *available at* 2003 WL 2799098.

224. Zambia acceded to the ICESCR on July 10, 1984. *Status of Ratifications*, *supra* note 86, at 11.

225. Catholics for a Free Choice, *supra* note 218.

226. Even in the United States under the current Bush administration, the politically powerful right wing has compelled the government to scale back information it was providing on the effectiveness of condom promotion and usage. U.S. House of Representatives Committee on Government Reform-Minority Staff Special Investigation Division, *Politics and Science in the Bush Administration, Prepared for Representative Henry A. Waxman*, *available at* http://www.house.gov/reform/min/politicsandscience/pdfs/pdf_politics_and_science_rep.pdf (last updated Nov. 13, 2003).

teachings rather than on the scientifically proven intervention of condom usage are not fulfilling their duty to create conditions in which the right to health can be realized.

3. *Applying International Human Rights Standards*

While the right to religion protects the right of the Church hierarchy, and all of its followers, to believe that abstinence is the preferred method for avoiding AIDS, the right is, and should be made, subject to limitations that are necessary for public health. Withholding information about the effectiveness of the correct use of condoms as a protection from HIV/AIDS, and tolerating widespread misinformation, violates the public's right to the highest attainable standard of physical and mental health.

Restricting information about condoms also violates specific norms that are incorporated in the right to health, namely, availability, accessibility, and quality.[227] Restrictions on information interfere with availability and accessibility because they result in an overall reduced availability of condoms, as well as information about their proper use. In addition, restrictions result in a lower quality of health care since the public is denied accurate and timely information on the effectiveness of a proven intervention.

Such policies also interfere with the full realization of other human rights. For example, the ICESCR recognizes a right to an education that is directed to the full development of the human personality and her sense of dignity.[228] Failing to provide adequate information on the overwhelming effectiveness of condoms in preventing sexually transmitted infections denies the public knowledge that would allow them to take effective steps to maintain their health. In addition, failing to publicize the effectiveness of condom usage in combating HIV/AIDS interferes with the right to enjoy the benefits of scientific progress and its applications, as provided in Article 15 of the ICESCR. It denies people access to the scientific knowledge discovered through the testing of condom effectiveness against HIV/AIDS, as well as access to an effective invention.

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227. *See supra* text accompanying notes 101-105.

228. Such a right is provided for in Article 13 of the ICESCR. ICESCR, *supra* note 77, at art. 13.

Given the gravity of the AIDS pandemic, governments have an obligation to ensure that their actions reduce the burden of the disease, not add to it. In addition to being bad public health policy, government restrictions on access to condoms, or the restriction of or failure to provide accurate information about their effective use, violates human rights. To be consistent with their obligations under international law, governments should promote the use of condoms notwithstanding any particular religion's position on the subject.

B. Female Genital Mutilation and Associated Public Health Risks

As stated above, in order to protect and advance the right to health appropriately, governments must discourage activities that are detrimental to the public's health and implement measures that promote it. If religious rites represent a significant danger to the public health, governments should work to curtail the practices even if doing so interferes with the practice of religion.

Given the adverse health consequences stemming from the widespread practice of FGM, governments in countries where the practice is followed should take the steps necessary to eradicate this practice. Although FGM is often performed as an Islamic practice, government policies restricting the right of adherence to this practice are acceptable and, in fact, mandated, under international human rights law. While the proper formula for eradicating FGM will vary in each country and will likely include a combination of legislation and outreach education, any effort must include legislation that infringes on the religious practice to the extent necessary to protect the public health of the population.

1. *The Risk of FGM to Public Health*

The scope and geographical breadth of the practice contributes significantly to the serious risks it poses to public health. In most cases, the procedure is performed on girls between the ages of four and twelve, although it is practiced in some cultures as early as a few days after birth and, in other cultures, as late as just prior to marriage or after the first pregnancy.[229] It is estimated that between 100,000,000 and

229. CENTER FOR REPRODUCTIVE LAW AND POLICY (NOW THE CENTER FOR REPRODUCTIVE RIGHTS), FEMALE GENITAL MUTILATION: A MATTER OF HUMAN RIGHTS: AN

140,000,000 girls and women have undergone FGM and that, each year, a further 2 million girls are at risk of undergoing the procedure.[230] Most of the procedures take place on girls and women in 28 countries in Africa,[231] with pervasiveness ranging from a low of 5 percent of the female population in the Democratic Republic of Congo and Uganda, to a high of 98 percent in Somalia and Djibouti.[232] It is also performed in the Middle East and Asia, and the practice has spread along migration paths to Europe, Australia, Canada, and the United States.[233]

There are several different forms of FGM. In the least severe form, the prepuce (foreskin) is excised and a part of the clitoris may be excised as well. In a more severe type, the clitoris and part or all of the labia minora are excised. This is the most common type of FGM, accounting for up to 80 percent of cases.[234] The third, most severe form, referred to as infibulation or pharaonic circumcision, constitutes excision of part or all of the external genitalia and the stitching (for the purpose of narrowing) of the vaginal opening.[235] It is estimated that 15 percent of circumcisions performed are infibulation, although this figure varies according to country.[236] In Djibouti, Somalia, and Sudan, for

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ADVOCATE'S GUIDE TO ACTION 7 (2003) [hereinafter CPR HUMAN RIGHTS GUIDE ON FGM] (citing NAHID TOUBIA, A CALL FOR GLOBAL ACTION 9 (2d ed. 1995)); *see also* WHO FACT SHEET ON FGM, *supra* note 48 (stating that the most common subjects of FGM are female infants, children and adolescents, and that FGM is occasionally performed on mature women as well).

230. WHO FACT SHEET ON FGM, *supra* note 48; *see also* CPR FACT SHEET ON FGM, *supra* note 45 (estimating that 130 million girls and women have undergone FGM and that an additional 2 million undergo the procedure each year).

231. WHO FACT SHEET ON FGM, *supra* note 48; CPR FACT SHEET ON FGM, *supra* note 45.

232. CPR FACT SHEET ON FGM, *supra* note 45. There are seven countries in which 90 percent or more of the females undergo FGM. CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 52-53.

233. WHO FACT SHEET ON FGM, *supra* note 48; CPR FACT SHEET ON FGM, *supra* note 45.

234. WHO FACT SHEET ON FGM, *supra* note 48; *see also* CPR FACT SHEET ON FGM, *supra* note 45.

235. WHO FACT SHEET ON FGM, *supra* note 48. There are a few other, much less common forms of FGM: pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (*angurya* cuts) or cutting of the vagina (*gishiri* cuts); and introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it. *Id.*

236. *Id.*; CPR FACT SHEET ON FGM, *supra* note 45.

example, approximately 80-90 percent of all circumcisions are of this type.[237]

The health consequences of FGM vary according to the form of circumcision performed and the conditions under which it is performed.[238] Immediate consequences include severe pain, shock, and the risk of fatal hemorrhage.[239] The procedure often results in infection, both local and systemic, which can also prove fatal for the girl or woman. In addition, abscesses, ulcers, septicemia, tetanus, and gangrene have all been documented consequences of FGM. Long-term implications include anemia; recurrent urinary tract infections that may affect the bladder, kidneys, and ureters; keloid scar formation; dermoid cysts; damage to the urethra resulting in urinary incontinence (often resulting in frequent urinary tract infections); obstruction of menstrual flow leading to frequent infections in the reproductive tract and infertility; dysparenuia (painful sexual intercourse); sexual dysfunction; and prolonged and obstructed childbirth with increased risk of fetal brain damage and fetal loss.[240] In the Sudan, 20-25 percent of infertility has been traced to infibulation.[241] FGM also results in an increased likelihood of transmission of HIV, due to use of the same instruments in multiple procedures, increased likelihood of lacerations in the resultant smaller vaginal opening, and increased occurrence of anal intercourse due to difficulties penetrating the vaginal opening.[242]

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237. CPR FACT SHEET ON FGM, *supra* note 45.

238. A limited number of studies exist on the short- and long-term physical effects of FGM; there have been even fewer studies on the psychological and psychosexual consequences of the practice. Nonetheless, reputed organizations such as the WHO have stated without qualification that "the physical, psycho-sexual and psychological complications of FGM are sizeable and constitute in some countries a serious public health problem which endangers the life and health of women and children." WORLD HEALTH ORGANIZATION, DEPARTMENT OF WOMEN'S HEALTH, HEALTH SYSTEMS AND COMMUNITY HEALTH, FEMALE GENITAL MUTILATION: INFORMATION KIT, *available at* http://www.who.int/docstore/ frh-whd/PDFfiles/FGM_info_pack.pdf (May 1999) [hereinafter WHO FGM INFORMATION PACK].

239. *Id.* (providing a detailed description of the short- and long-term health consequences).

240. *Id.*; WHO FACT SHEET ON FGM, *supra* note 48; STEINER & ALSTON, *supra* note 46, at 242-43 (citing *A Traditional Practice that Threatens Health – Female Circumcision*, 40 WHO CHRONICLE 31 (1986)).

241. STEINER & ALSTON, *supra* note 46, at 242 (citing *A Traditional Practice that Threatens Health – Female Circumcision*, 40 WHO CHRONICLE 31 (1986)).

242. HUMAN RIGHTS WATCH, POLICY PARALYSIS: A CALL FOR ACTION ON HIV/AIDS-RELATED HUMAN RIGHTS ABUSES AGAINST WOMEN AND GIRLS IN AFRICA 53-54 (Dec. 2003)

Furthermore, although there have not been many studies of the psychological and psychosexual effects, it is believed that there are serious consequences in these areas as well, including anxiety and depression.[243]

There are additional health risks associated with infibulation, the most extreme form of FGM. When a woman who has undergone infibulation gets married, her husband will gradually undo the stitching of the vaginal opening to allow the couple to have intercourse; if the husband is unable to accomplish this himself, the woman will be cut.[244] Likewise, when an infibulated woman goes into labor, she must be "defibulated," and there are often complications due to scar tissue.[245] An infibulated woman is likely to develop chronic pelvic infections, which may spread to other organs.[246]

2. *The Religious Basis of FGM*

Some Muslim communities practice FGM in the belief that it is demanded by the Islamic faith.[247] There is some evidence supporting this interpretation in Islamic texts, including a *hadith* in which the Prophet Muhammad offered instruction on the procedure,[248] and another

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("Although few clinical studies have been conducted, it is clear that at least some forms of FGM increase the HIV transmission risk faced by women and girls, both in that unsterile instruments may be used in the cutting and because some FGM is associated with chronic genital injury and tearing, ulceration, and delayed healing of injuries, all of which may increase HIV risk.") (citing Margaret Brady, *Female Genital Mutilation: Complications and Risk of HIV Transmission*, 13 AIDS PATIENT CARE AND STDS 709-716 (1999)); WHO FGM INFORMATION PACK, *supra* note 238.

243. WHO FACT SHEET ON FGM, *supra* note 48; WHO FGM INFORMATION PACK, *supra* note 239 (explaining in detail the possible psychological and psycho-sexual consequences).

244. WHO FGM INFORMATION PACK, *supra* note 238.

245. *Id.*

246. *Id.*

247. Other bases for the practice include sociological reasons, including custom and identification with cultural heritage, initiation into womanhood, social integration; psychosexual reasons, including that it will harness sexual desire, maintain chastity before marriage and fidelity during marriage, and increase male sexual pleasure; hygiene and aesthetic reasons; and myths such as that FGM will bring luck to the woman's offspring. WHO Fact Sheet on FGM, *supra* note 48; STEINER & ALSTON, *supra* note 46, at 243 (citing *A Traditional Practice that Threatens Health – Female Circumcision*, WHO CHRONICLE 31 (1986)).

248. A *hadith* is a report of the sayings or activities of the Prophet Muhammad and a source of Islamic law. According to this *hadith*, the Prophet told Umm Attia, a woman who performed female circumcisions, "Umm Attia, restrict yourself to a sniff and do not overstrain; (this way), it is more pleasant in appearance and more satisfactory to the husband."

in which the Prophet Muhammad said that female circumcision is a sign of respect.[249] The authenticity of these *hadiths* is disputed by some Islamic scholars,[250] and many scholars dispute that FGM has any basis in Islam.[251] For the purposes of this analysis, however, the actual basis of FGM in Islam is immaterial. What is relevant is that many people performing and undergoing FGM operate under the belief that they are complying with the tenets of their religion. As a result, this practice may be considered to fall within the scope of the right to free exercise of religion.

3. *Applying International Human Rights Standards to the Practice of FGM*

The negative health consequences of FGM have a clear impact on the achievement of the right to health. A procedure that removes human tissue and organs when it is not medically necessary, and causes dire physical and mental health consequences, compromises the right of females, both children and adults alike, to the "highest attainable standard of physical and mental health."[252]

Governments are under an obligation to take affirmative measures to facilitate and promote the right to health and to provide the means to enable people to enjoy the right, an obligation that includes the provision of access to health information.[253] In the face of the health risks

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MUHAMMAD LUTFI AL-SABBAGH, ISLAMIC RULINGS ON MALE AND FEMALE CIRCUMCISION (1996), *available at* http://www.emro.who.int/Publications/HealthEdReligion/CircumcisionEn/. This has also been translated as "[d]o not cut severely as that is better for a woman and more desirable for a husband." ROBERT SPENCER, ISLAM UNVEILED: DISTURBING QUESTIONS ABOUT THE WORLD'S FASTEST-GROWING FAITH 88 (2002).

249. According to this hadith, the Prophet said to Usama al-Huthali: "Circumcision is a *sunna* for men and a sign of respect for women." LUTFI AL-SABBAGH, *supra* note 249.

250. *See id.* With respect to the first *hadith* mentioned, some scholars who accept its authenticity contend that it does not require circumcision but, rather, urges caution in the event that female circumcision is to be performed. *See id.*

251. *See* WHO FACT SHEET ON FGM, *supra* note 48 (stating that the practice, in fact, predates Islam); CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 8 ("It is important to note that FC/FGM is a cultural, not religious, practice."); STEINER & ALSTON, *supra* note 46, at 243 (citing *A Traditional Practice that Threatens Health – Female Circumcision*, WHO CHRONICLE 31 (1986)) (stating that there is no support for FGM in the Koran and pointing to the fact that it is not practiced in Saudi Arabia, "the cradle of Islam").

252. CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 229, at 17.

253. General Comment 14, *supra* note 94, ¶¶ 33, 43-45.

associated with FGM, it is the obligation of governments in countries in which FGM takes place to disseminate accurate information about the health threats it poses.

The international health community has recognized the danger that FGM poses to women's health since the 1950s.[254] Subsequently, international health and human rights bodies and instruments have described FGM as a violation of the right to health and, consequently, a human rights violation; these include the Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993,[255] the Convention on the Rights of the Child,[256] and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[257] Recently, the WHO issued a joint statement with the United Nation Children's Fund (UNICEF) and the UN Population Fund (UNFPA) calling for, and issuing a plan for, the elimination of FGM.[258]

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254. WHO FGM INFORMATION PACK, *supra* note 238 (noting that the UN Commission on Human Rights discussed the issue of FGM in 1952); CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 229, at 10, 14. In 1979, the WHO sponsored the first Seminar on Harmful Traditional Practices Affecting the Health of Women and Children in Khartoum (Sudan), in which FGM was discussed, a proposal that FGM be performed only in hygienic conditions was rejected, and recommendations were issued to governments to eliminate the practice. *Id.* at 10; WHO FGM INFORMATION PACK, *supra* note 238. The WHO has steadfastly opposed the "medicalization" of FGM:

> Given WHO's commitment to advance the health, and protect the lives of women and children, including their reproductive and psychological health, the Organization continues to advise unequivocally that FGM must not be institutionalized, nor should any form of FGM be performed by any health professionals in any setting, including hospitals or other health establishments.

Id.

255. *Declaration on the Elimination of Violence Against Women*, G.A. Res. 104, U.N. GAOR, 48th Sess., at art. 2(a) U.N. Doc. A/RES/48/104 (1993) (characterizing FGM as a form of violence).

256. *See generally* CRC, *supra* note 90.

257. *See generally* CEDAW, *supra* note 90. For other relevant international instruments, see International Conference on Population and Development, Cairo, Egypt, September 5-13, 1994, A/CONF: 171/13/Rev. 1; *see also* Beijing Declaration and Platform for Action, Fourth World Conference on Women, September 15 1995, 35 I.L.M. 401 (1996), *available at* http://www1.umn.edu/humanrts/instree/e5dplw.htm.

258. WORLD HEALTH ORGANIZATION, FEMALE GENITAL MUTILATION: A JOINT WHO/UNICEF/UNFPA STATEMENT (1997).

Due to the significant negative health consequences caused by FGM, governments in countries where FGM is practiced are obligated, under international human rights law, to enact policies consistent with the scientific principles that identify the clear public health risk of FGM.[259] As discussed above, limitations can be placed on religious practices when necessary to protect public health as long as the limitations are established by law, directly related and proportional to public health, and nondiscriminatory. In this case, governments in countries where FGM is practiced should take the steps necessary to achieve the eradication of this practice, despite the ensuing interference with religious-based practices, in order to fully effectuate the right to health.[260]

Government policies that allow FGM to continue interfere with the full realization of other human rights as well, including the right to physical integrity,[261] the right to be free of gender discrimination,[262] and

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259. Of the 41 countries in which the practice of FGM has been documented, all are signatories to the ICESCR except for Djibouti, Eritrea, Ghana, Liberia, Mauritania, and the United States. Of these, all but Eritrea and the United States are signatories to the African Charter on Human and Peoples' Rights (the Banjul Charter), which describes the right to health in language identical to the ICESCR and requires state parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. African Charter, *supra* note 76, at art. 16. Inasmuch as the UDHR and the right to health codified therein is accepted as customary international law, the right to health is binding on all nations regardless of their signing of the ICESCR or other agreements. *See supra* note 82 and accompanying text.

260. Some women's rights advocates argue that women who are of consenting age and who give their informed consent should be allowed the autonomy to make the decision of whether they wish to undergo FGM. *See, e.g.*, CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 229, at 30-31. The ability to manifest one's religion, however, is clearly subject to restrictions under international law.

261. *See, e.g.*, UDHR, *supra* note 74, at art. 3 (stating that "[e]veryone has the right to life, liberty and security of person."). The right to physical integrity "encompasses a number of broader human rights principles, including the inherent dignity of the person, the right to liberty and security of the person, and the right to privacy." CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 16.

262. The right to be free from gender discrimination is guaranteed in numerous international human rights instruments. *See, e.g.*, CEDAW, *supra* note 90, at art. 1 (defining discrimination against women as "any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field"). The Committee on the Elimination of Discrimination Against Women, the body that monitors implementation of the Convention, has recently issued a General Recommendation on Women and Health that includes a recommendation that governments devise health policies that take into account the needs of girls and adolescents who

children's rights.[263] When the public health implications of FGM as well as the risks to other fundamental human rights are weighed against the infringement upon the right to religion, it becomes clear that government policies on the practice of FGM must be dictated by science.

Several governments in Africa and elsewhere have already taken steps to eliminate FGM, which include criminalizing the practice, efforts at education and outreach programs, and the use of civil remedies and administrative regulations to prevent the practice.[264] These measures limit the right to manifest religion but they are justified by their advancement of the right to health. Although FGM is often performed as an Islamic practice, government policies restricting the right of adherence to this practice are consistent with international law. As a result, they are legitimate exercises of state power. Based on the same rationale, countries that have not yet taken the necessary affirmative steps to eliminate FGM may be obligated to do so.

The proper formula for eradicating FGM will vary in each country and will likely include a combination of legislation and outreach education. National legislation that prohibits FGM can provide a particularly effective tool for eliminating the practice. Legislation must clearly proscribe FGM and it must not be subject to selective application. In countries in which only minority populations engage in FGM, the government should ensure that the legislation is not used in a discriminatory fashion to harass or persecute members of the minority group.[265] Any effort undertaken may include legislation that infringes upon religious practices to the extent necessary to protect the public

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may be vulnerable to FGM. *See* CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 17.

263. *See, e.g.*, CRC, *supra* note 90. The Convention protects the rights to gender equality (Art. 2), to be free from all forms of mental and physical violence and maltreatment (Art. 19.1), to the highest attainable standard of health (Art. 24.1), and to be free from torture or cruel, inhuman and degrading treatment (Art. 37.a). *See id.* Because FGM is most often performed on girls, who are not in a position to give informed consent, it is widely considered to be a violation of children's rights. *See* WHO FGM INFORMATION PACK, *supra* note 239; CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 18.

264. CPR FACT SHEET ON FGM, *supra* note 45. Twelve African countries have enacted laws criminalizing FGM, with penalties ranging from monetary fines to prison terms of six months up to a life sentence. *See id.* Many of these countries have also taken steps to enforce these laws through prosecution and arrest. *See id.* Industrialized nations in which FGM is performed are also responding with legislation; eight nations have passed laws criminalizing the practice. In the United States, for example, a federal law and 16 state laws have been enacted criminalizing FGM. *See id.*

265. *See* CPR HUMAN RIGHTS GUIDE ON FGM, *supra* note 230, at 31.

health of the population. Effective efforts could also include a widespread public information campaign on the health dangers of FGM.

C. Immunization Policy

Government-mandated immunization requirements comprise another area where religion and public health sometimes come into conflict. Immunization (or vaccination)—which involves the "administration of a vaccine or toxoid used to prevent, ameliorate, or treat infectious disease"—has long been used as an effective public health tool against infectious disease outbreaks.[266] The Centers for Disease Control and Prevention (CDC) has recognized vaccines as "one of the greatest achievements of biomedical science and public health."[267] The administration of vaccines, however, has not been without controversy. Frequently, public health and religious interests regarding immunizations clash, particularly when a religious practitioner opposes any medical treatment at all.[268] Religious objections to immunization requirements have been articulated persistently since Edward Jenner first proved the usefulness of vaccination for the prevention of smallpox infection in 1796.[269]

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266. Lawrence O. Gostin, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 180 (2000). The terms "vaccination" and "immunization" have similar definitions and therefore are frequently used interchangeably. "Immunization," which involves the administering of an immunobiologic to induce an immune response, is the more inclusive term. "Vaccination" is another term for active immunization, which introduces a vaccine into the host and provokes an immune response, causing the host to make antibodies. Passive immunization involves administering antibodies directly to the recipient, resulting in shorter-term protection from infection. *See id.* at 180 n.23; W. Michael McDonnell & Frederick K. Askari, *Immunization*, 278 JAMA 2000 (1997). Since this article focuses on exemptions to either active or passive immunization requirements, we predominantly use the term "immunization".

267. *See generally* Centers for Disease Control & Prevention, *Impact of Vaccines Universally Recommended for Children – United States, 1900-1998*, 281 JAMA 1482 (1999); *see also* Gro Harlem Brundtland, *State of the World's Vaccines and Immunizations*, 288 JAMA 2532 (2002) (discussing the important impact vaccines have had on public health).

268. *See* Timothy J. Aspinwall, *Religious Exemptions to Childhood Immunization Statutes: Reaching for a More Optimal Balance Between Religious Freedom and Public Health*, 29 LOY. U. CHI. L.J. 109, 112-17 (1997) (discussing the friction between public health and religious freedom).

269. Other objections to vaccination question the scientific efficacy of vaccines, raise the possibility of harmful health effects (e.g., negative reactions or transmission of disease), and present philosophical opposition to receiving vaccination. *See id.*; *see also* James G. Hodge, Jr. & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal*

Very high immunization rates are necessary to prevent infectious disease outbreaks in a given population. Religious exemptions from immunization requirements reduce these immunization rates and may make it difficult to achieve the necessary levels of immunity to protect public health. An under-immunized population is more susceptible to an infectious disease outbreak. Indeed, the risk of an outbreak increases as immunization rates decrease.[270] Therefore, restricting additional exemptions from immunization requirements may be consistent with protecting population health in populations with insufficient levels of immunity.

The right to free exercise of religion does not obligate states to accommodate religious exemptions from immunization requirements. When such exemptions foster a public health risk, they may be denied in accordance with the public health exception to the right to free exercise of religion. Thus, according to international human rights requirements, governments should not allow religious exemptions from immunization requirements where the immunity levels in a given population are insufficient to prevent a potential or actual outbreak of disease.

1. *Importance of Immunization to Public Health*

Immunization is an established and effective means of preventing infectious disease epidemics as well as a means for slowing or stopping the spread of endemic infectious diseases. Immunization drastically reduces the morbidity and mortality caused by a number of diseases that may affect humans, including smallpox, influenza, measles, and polio.[271] In fact, the implementation of widespread immunization requirements in the United States has reduced childhood morbidity for

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*Perspe*ctives, 90 KY. L.J. 832, 844 (2002). *But see* Ross D. Silverman & Thomas May, *Private Choice Versus Public Health: Religion, Morality, and Childhood Vaccination Law*, 1 MARGINS 505, 520-21 (2001) (outlining moral arguments why personal exemptions to immunization should not be permitted under John Stuart Mill's Harm Principle).

270. *See* Hodge & Gostin, *supra* note 270, at 881 (analyzing studies that demonstrate that "[l]ow rates of immunization may lead to outbreaks of disease").

271. *See* Centers for Disease Control & Prevention, *Ten Great Public Health Achievements – United States, 1900-1999*, 48 MORBIDITY & MORTALITY WKLY. REP. 241, 241 (1999). Vaccinations have also been used to combat mumps, rubella, diptheria, chickenpox (varicella), pertussis, tetanus, and Hepatitis B, among other infectious diseases. *See* Hodge & Gostin, *supra* note 269, at 833.

vaccine-preventable diseases (VPD) by 95 to 100 percent.[272] On the global level, ambitious immunization programs have helped to eradicate the smallpox virus completely[273] and have nearly eradicated the polio virus.[274] The ability to apply a proactive immunological intervention to populations through immunization initiatives has allowed for these great successes.

Vaccines are usually effective, but they are not always a panacea for stopping the spread of infectious diseases. Although vaccines provide immunity to the majority of recipients, in some cases vaccine recipients become infected despite immunization. This may occur if the vaccine is administered improperly, if it has been manufactured incorrectly, or if a complete course of treatment is not followed.[275] Furthermore, vaccines can have adverse health effects on small segments of the population.[276] It is important to keep in mind, however, that the risk of

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272. *See* Kevin M. Malone & Alan R. Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights, in* LAW IN PUBLIC HEALTH PRACTICE 265-66 (Richard A. Goodman et al. eds., 2003).

273. Until the middle of the 20th century, smallpox was one of the most feared diseases on earth. The WHO embarked upon an effort to eradicate smallpox worldwide, a feat that was achieved in 1978. *See generally* DAVID A. KOPLOW, SMALLPOX: THE FIGHT TO ERADICATE A GLOBAL SCOURGE (2003) (discussing the smallpox eradication campaign). While there is no naturally-occurring smallpox virus anywhere in the world, it is feared that smallpox could be used as a bioterror weapon. *See* Donald A Henderson, *The Looming Threat of Bioterrorism*, 283 SCI. 1279, 1280 (1999).

274. The WHO has embarked on a focused effort to eradicate polio. Information about this campaign is available at www.polioeradication.org. Recently, the health ministers from a number of countries signed the Geneva Declaration for the Eradication of Poliomyelitis. *See* Geneva Declaration for the Eradication of Poliomyelitis, *available at* http://www.polioeradication.org/content/publications/20040115_declaration.pdf (Jan. 5, 2004).

275. *See* Centers for Disease Control & Prevention, *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians (AAFP)*, 51 (RR-2) MORBIDITY & MORTALITY WKLY. REP. 1, 6-11 (2002) (describing situations where health practitioners may have to re-administer or assess the vaccination status of a patient); C.R. Vitek et al., *Increased protections during a measles outbreak of children previously vaccinated with a second dose of measles-mumps-rubella vaccine*, 18 PEDIATR. INFECT. DIS. J. 620 (1999) (finding that a second does of MMR vaccine improved immunity protections).

276. *See* Centers for Disease Control & Prevention, *Update: Vaccine Side Effects, Adverse Reactions, Contraindications, and Precautions: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, 45 (RR-12) MORBIDITY & MORTALITY WKLY. REP. 1 (1996) (summarizing adverse reactions for vaccines). The United States has implemented a comprehensive reporting system to track adverse events from vaccines called the Vaccine Adverse Event Reporting System (VAERS). *See* J. A. Singleton et al., *An overview of the vaccine adverse event reporting system (VAERS) as a surveillance system*, 17 VACCINE 2908 (1999).

morbidity and mortality from an infectious disease outbreak is many times higher than that from adverse vaccine reactions.[277] In sum, vaccines provide an inexpensive, effective, and generally safe method to protect the public against a number of infectious diseases, with little individual risk to any particular recipient.

2. *Religious Opposition and Exemptions to Immunization*

Opposition to immunization has existed almost as long as immunization itself.[278] Early anti-vaccinationists disputed the effectiveness of immunization practices and campaigned against the imposition of mandatory immunization requirements. Much of this early opposition was founded upon religious beliefs that reject medical treatment, a position that continues to this day among numerous religious denominations.[279] Christian Scientists, for example, believe that disease is caused by a lack of spiritual wholeness and healing may only be accomplished through prayer. As a consequence they often refuse to accept medical treatment for any condition.[280] Likewise, the Amish community in the United States eschews all forms of modern technology, including advances in medicine.[281]

In deference to the rights of members of these and other groups, religious exemptions from immunization requirements have been adopted widely in the United States, and in other parts of the world. In the United States, forty-seven states have enacted some form of religious exemption from mandatory immunization requirements.[282]

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277. *See* Hodge & Gostin, *supra* note 270, at 888.

278. *See id.*, at 840-49 (discussing the use of compulsory smallpox vaccination programs in the United States, England, France, Germany, Denmark, Russia, and Sweden in the early 19th century).

279. *See id.* at 849; *see also* JOHN H. MOXLEY, III, REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS: RELIGIOUS EXEMPTIONS FROM IMMUNIZATIONS 7 (1987) (listing religious groups opposed to immunization).

280. *See generally* Janna C. Merrick, *Spiritual Healing, Sick Kids and the Law: Inequities in the American Healthcare System*, 29 AM. J.L. & MED. 269 (2003) (discussing the health and medical beliefs of Christian Scientists); *See also supra* text accompanying notes 49-52.

281. *See generally* THE AMISH AND THE STATE 3 (Donald B. Kraybill ed., 1993) (outlining the attitudes of the Amish towards science and medical treatment).

282. *See* Hodge & Gostin, *supra* note 269, at 869-73 (summarizing state vaccination laws and requirements); Ross D. Silverman, *No More Kidding Around: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANNALS HEALTH L. 277, 282-83 (2003) (discussing state school immunization laws).

These exemptions do not operate automatically. Rather, states retain the ability to deny exemptions when the public's health is at risk. Indeed, the courts have consistently backed the government's public health justifications for immunization and accordingly have denied religious exemptions when the public health is threatened.[283] These decisions are grounded on the premise that individual autonomy interests invoked by those seeking a religious exemption are outweighed by the potential detriment to the common good that would result if exceptions were made to certain immunization policies.

3. *Religious Exemptions and the Risk to Public Health*

Immunization does not always present an irresolvable policy dispute between health and religion. The existence of religious exemptions from immunization requirements does not lead to negative public health consequences when religious exemptors comprise only a miniscule portion of the general population. It is only when a large number of unvaccinated persons are present within a community that the exemption of additional persons may place the larger population at an increased risk of infection.

When the number of exemptors is low and evenly distributed, and the proportion of immunized individuals is high, the population may benefit from what is known as "herd immunity."[284] Herd immunity occurs when a large percentage of the population has immunity to a disease. Due to this widespread immunity in the population, the likelihood of disease transmission substantially decreases. Individuals that do not have immunity receive indirect protection from the disease due to the reduced community-wide likelihood of transmission.[285] Consequently, it is not necessary to immunize 100 percent of a given population. As

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283. *See* Hodge & Gostin, *supra* note 269, at 859-75 (discussing in depth U.S. case law regarding religious exemptions to vaccination requirements). Three seminal U.S. Supreme Court cases have determined the parameters of governmental power to compel immunization over a religious objection or otherwise protect the welfare or health of a child in contravention of a parent's religious beliefs: Jacobson v. Massachusetts, 197 U.S. 11 (1905) (finding that the government was authorized to compel vaccination for the public good); Zucht v. King, 260 U.S. 174 (1922) (upholding a government mandate for vaccination as a prerequisite for public school attendance); Prince v. Massachusetts, 321 U.S. 158 (1944) (holding that the right to free exercise of religion does not permit the exposure of the community or one's children to disease).

284. *See* Malone & Hinman, *supra* note 273, at 264.

285. LEON GORDIS, EPIDEMIOLOGY 18 (1996).

long as a sufficiently high rate of immunization is achieved, herd immunity will protect the entire population from infection.[286]

The level of immunity required for herd immunity in a particular population varies according to a number of factors, including the contractibility of the disease, the effectiveness and duration of the protection offered by the vaccine,[287] the number of medically contra-indicated individuals in the population,[288] and resource limitations affecting the provision and distribution of immunizations. Rates adequate for inducing herd immunity are estimated at 94 percent for measles, and approximately 80 percent for poliomyelitis.[289] As long as herd immunity is maintained, religious exemptions may be accommodated without endangering the health of the larger population.

On the other hand, religious exemptions may undermine efforts to achieve herd immunity with respect to a given disease. The granting of religious exemptions increases the number of non-immunized persons in the population, thereby decreasing the overall level of immunity.[290] When the rate of immunization for the community falls below the level required to induce herd immunity, the entire community is subject to an increased risk of disease outbreaks. Studies of measles and pertussis outbreaks have demonstrated that exemptors face a much higher risk of contracting VPDs than immunized populations.[291] Thus, the risk of

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286. *Id.*

287. Some vaccines last throughout a person's lifespan, while others have a limited duration and must be re-administered to retain their effectiveness.

288. Some members of the population will be unable to receive immunization for medical reasons that place them at higher risk for adverse reactions to the vaccine; these individuals are referred to as "medically contra-indicated."

289. *See* Alan R. Hinman et al., *Tools to Prevent Infectious Disease: Childhood Immunization: Laws that Work*, 30 J.L. MED. & ETHICS 122, 125 (2002).

290. Since the incidence of VPDs is likely to be low in a highly immunized population, individuals may be more tempted to claim a religious exemption, thereby avoiding the remote individual risk of receiving the vaccine and relying on herd immunity for disease protection. *See generally* Garret Hardin, *The Tragedy of the Commons*, 162 SCI. 1243 (1968) (generally discussing the relationship between individual and societal interests).

291. *See* Daniel A. Salmon et al., *Health Consequences of Religious and Philosophical Exemptions From Immunization Laws: Individual and Societal Risk of Measles*, 281 JAMA 47, 49-51 (1999) (finding that exemptors were 35 times more likely to contract measles than were vaccinated persons); Daniel R. Feikin et al., *Individual and Community Risks of Measles and Pertussis Associated With Personal Exemptions to Immunization*, 284 JAMA 3145, 3147-48 (2000) (finding that exemptors were 22.2 times more likely to acquire measles and 5.9 times more likely to acquire pertussis than vaccinated children).

infection increases for members of the population who have not been immunized, including those exempted on religious and non-religious grounds (e.g., those not immunized due to preexisting medical conditions, and those not immunized for reasons related to access, resources, and logistical constraints).[292]

Since vaccines are not 100-percent effective, the loss of herd immunity may affect even those who are immunized. One study found evidence that contact between exemptors and vaccinated children resulted in an increased transmission of measles infection in the vaccinated population as well.[293]

Herd immunity can only exist where immunity is evenly distributed throughout the population. Thus, subpopulations that possess higher numbers of religious exemptions are more likely to have localized outbreaks. Since religious groups that oppose immunization often cluster in certain geographic areas and communities, these communities are less likely to have a level of immunity sufficient to achieve herd immunity.[294] Outbreaks among these subpopulations have devastating effects. A number of such outbreaks have been documented among groups espousing religious opposition to immunization.[295] Also, due to the increased susceptibility of religious exemptors to VPDs, they are more likely to perpetuate an outbreak through multiple generations of transmission. In one study, a population with a relatively large concentration of exemptors was shown to have transmitted measles through six generations.[296] This results in a prolonged period in which others in the community are at an increased risk.

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292. *See* Hodge & Gostin, *supra* note 270, at 880-83 (discussing the effect of low vaccination rates and access barriers to vaccination as factors in disease outbreaks).

293. *See* Feikin et al., *supra* note 292, at 3149; *see* Silverman, *supra* note 283, at 284-85 (discussing studies of religious exemptors).

294. *See* Thomas May & Ross D. Silverman, *Clustering of Exemptions As A Collective Action Threat to Herd Immunity*, 21 VACCINE 1048 (2003).

295. *See* Salmon et al., *supra* note 291 (documenting measles outbreaks among religious exemptors); Centers For Disease Control & Prevention, *Outbreak of Measles Against Christian Science Students – Missouri and Illinois, 1994*, 43 MORBIDITY & MORTALITY WKLY. REP. 463 (1994); Feiken, *supra* note 291 (documenting measles and pertussis outbreaks among religious exemptors).

296. *See* Salmon et al., *supra* note 291, at 51.

4. *Applying International Human Rights Standards to Religious Exemptions from Immunization*

The internationally recognized right to health requires that governments ensure a sufficient level of population-wide immunization. Article 12.2 of the ICESCR specifically articulates a right to prevention, treatment, and control of diseases. According to the CESCR, this right includes "the implementation or enhancement of immunization [programs] and other strategies of infectious disease control."[297] General Comment 14 considers immunization to be a high priority obligation for states in upholding the right to health.[298]

Governments should take measures to ensure an adequate level of immunization coverage for diseases with high morbidity and mortality rates in order to fulfill the right to the highest attainable standard of physical and mental health. The state must provide "immunization [programs] against the major infectious diseases,"[299] respond to the needs of vulnerable groups (e.g., unvaccinated children),[300] and support people "in making informed choices about their health."[301]

Religious exemptions to immunization also may impede the full realization of other human rights. The inability of the state to restrict religious exemptions to a level that permits the achievement of herd immunity may interfere with the right to enjoy the benefits of scientific progress and its applications as provided for in Article 15 of the ICESCR. The population will be denied the scientific progress provided by the population-wide application of modern vaccine immunity.

Government policy should allow religious exemptions only when herd immunity has been realized in a particular community, and when there is evidence that religious exemptions, if granted, will not under-

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297. General Comment 14, *supra* note 94, ¶ 16.

298. *See id.* ¶ 44.

299. *Id.* ¶ 36.

300. *See id.* ¶ 37. General Comment 14 also separately requires the state to take "effective and appropriate measures to abolish harmful traditional practices affecting the health of children." *Id.* ¶ 22. Therefore, the state must undertake specific steps to avoid traditional practices, including religious practices, that harm children's health. *See id.* A decision by a parent to apply for a religious exemption for their child could conflict with the state's interest in protecting the child's health and welfare under General Comment 14 and the Convention on the Rights of the Child. *But see* ICCPR, *supra* note 83, art. 18.3 (protecting the rights of parents to make decisions for their children regarding religion).

301. *Id.* ¶ 37.

mine that immunity. When the population is well-vaccinated and herd immunity can be achieved in each community while continuing to allow for religious exemptions, doing so is acceptable and appropriate, as it does not pose a significant threat to public health. When immunization coverage levels in the population are insufficient to provide or maintain herd immunity, however, religious exemptions to immunization may pose a substantial threat to public health. In this latter situation, government authorization should not be given for religious exemptions to immunization. Such decisions should be made using scientific criteria based upon recent epidemiological evidence.

CONCLUSION

We have attempted in this article to shed light on the complexities of the relationship between the right to free exercise of religion and the right to health. The importance of both religion and health in the everyday lives of people around the world demands the serious and continued consideration of how these two rights interact with each other and affect human well-being. Religious customs and beliefs often correspond with or even bolster public health. When this is the case, government officials should permit the free exercise of religion without restraint. Conversely, when religious values and practices deviate from scientifically-proven health methods to the detriment of public health, governments have an obligation to limit religious manifestations for the public good.

The international human rights system provides a useful framework to evaluate conflicts that inevitably arise between the right health and the right to free exercise of religion. According to international human rights law, the right to free exercise of religion is not absolute. Instead, religious activities may be limited if they threaten the public's health. This limitation suggests that the duties of government in relation to protecting the health of the population supercede an unconditional right to practice religion. Coupled with a robust understanding of the international human right to health, it is clear that human rights law recognizes a restriction on the right to religion when the manifestations of belief jeopardize public health.