

Accountability for the human right to health through treaty monitoring: Human rights treaty bodies and the influence of concluding observations

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ABSTRACT

Employing novel coding methods to evaluate human rights monitoring, this article examines the influence of United Nations (UN) treaty bodies on national implementation of the human right to health. The advancement of the right to health in the UN human rights system has shifted over the past 20 years from the development of norms under international law to the implementation of those norms through national policy. Facilitating accountability for this rights-based policy implementation under the right to health, the UN Committee on Economic, Social and Cultural Rights (CESCR) monitors state implementation by reviewing periodic reports from state parties, engaging in formal sessions of 'constructive dialogue' with state representatives, and issuing concluding observations for state response. These concluding observations recognise the positive steps taken by states and highlight the principal areas of CESCR concern, providing recommendations for implementing human rights and detailing issues to be addressed in the next state report. Through analytic coding of the normative indicators of the right to health in both state reports and concluding observations, this article provides an empirical basis to understand the policy effects of the CESCR monitoring process on state implementation of the right to health.

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Introduction

Where the United Nations (UN) seeks to facilitate international accountability for national policy, this article examines UN efforts to monitor state implementation of the human right to health through the UN Committee on Economic, Social and Cultural Rights (CESCR). Examining the CESCR's concluding observations, which recognise the positive steps taken by states and highlight the principal areas of Committee concern, these concluding observations provide recommendations for the implementation of the right to health and outline issues to be addressed in the next state report. This article analyses correlations between the normative indicators of the right to health that are raised in the CESCR's concluding observations and the corresponding indicators that are raised in subsequent state reports.

The human right to health has been firmly established under international law, evolving since the birth of the UN to encompass normative attributes and principles over a wide range of determinants of health. Yet, despite an expansion of state support for the obligations of the right to health – evidenced by a steady increase in state ratification of the International Covenant on

Economic, Social and Cultural Rights (ICESCR) – studies have continued to show an ambiguous relationship between treaty ratification and human rights implementation. International treaty monitoring is seen as a principal mechanism to facilitate accountability for the implementation of the human right to health, with treaty bodies monitoring implementation by reviewing periodic reports from state parties, engaging in formal sessions of ‘constructive dialogue’ with state representatives, and issuing concluding observations for state response. With states authorising UN treaty bodies under international law, providing a mandate for international monitoring, such monitoring seeks to provide legal accountability for state implementation in the absence of a global judiciary, overcoming an ‘enforcement problem’ in human rights through state reporting and international assessment.

This article examines CESCR monitoring of state practices to implement the right to health. The background describes human rights treaty monitoring for the right to health, outlining the development of the right to health under international law and elaborating the processes through which the CESCR monitors state implementation of health obligations. To investigate these monitoring processes, this article then reviews the analytic coding methods by which this study researched indicators of the right to health in both state reports and CESCR concluding observations. Analysing associations between concluding observations and subsequent state reports, the results – examining indicators of both public health topics and human rights norms – provide empirical assessment of the influence of treaty monitoring on implementation of the right to health. The discussion assesses continuing deficiencies in this monitoring process, considering indicator-based reporting and public health data as a basis to facilitate accountability for human rights implementation.

Background

As a basis for global justice under international law, human rights stands as a central normative framework for global health, offering universal standards by which to frame government responsibilities and facilitate legal accountability (Gruskin, 2012). Following from the evolving development of the right to health over the past 70 years, the UN human rights system has shifted from the development of human rights under international law to the implementation of those rights through national policy (Hunt, 2017). Accountability for this national implementation may be facilitated through international monitoring, with the CESCR leading UN human rights treaty bodies in monitoring state obligations under the right to health (Meier & Brás Gomes, [forthcoming](#)).

Right to health

With the 1946 Constitution of the World Health Organisation (WHO) serving as the first international treaty to conceptualise a human right to health, states declared that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’, defining health positively to include ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (WHO, 1946, preamble). Drawing on the WHO Constitution, the UN General Assembly adopted the 1948 Universal Declaration of Human Rights (UDHR), including in it a set of interrelated rights to medical care and underlying determinants of health:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services... (UN General Assembly, 1948, art. 25).

From this birth of human rights for global health, the UN human rights system has sought to develop the right to health under international law, with human rights now addressing public health through an expansive and reinforcing set of international treaties and global standards (Yamin, 2005).

The 1966 ICESCR has provided seminal codification of this right under international treaty law, framing government obligations to progressively realise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (UN General Assembly, 1966, art. 12). Elaborating the normative content of this evolving right, the CESCR – the UN treaty body charged with both interpreting and monitoring the ICESCR – issued a General Comment in 2000 to provide authoritative interpretation of the normative attributes and principles of the human right to health (CESCR, 2000). In finding that there exist legal obligations to address ‘underlying determinants of health’, the Committee clarified in General Comment 14 that the right to health depends on a wide range of interconnected rights – beginning in preventive and curative care and expansively encompassing underlying rights to food, housing, work, education, equality, privacy and information (CESCR, 2000, p. 11). This human rights focus on determinants of health has since been extended by the UN Special Rapporteurs on the Right to Health, WHO Commission on Social Determinants of Health and UN General Assembly – moving toward a rights-based ‘health-in-all-policies’ approach under the Sustainable Development Goals (SDGs) (Hawkes & Buse, 2016).

Operationalising these human rights obligations, policymakers have sought to move from the development of health-related rights under international law to the implementation of these normative standards in national policy (UN, 2005). This implementation process, from the acceptance of international norms to the improvement of individual lives, does not occur automatically and is contingent on a long chain of programmatic steps, necessitating examination of national reforms at each stage of human rights implementation (Getgen & Meier, 2009). With human rights law framing national implementation efforts for underlying determinants of health, it is necessary to facilitate accountability for this implementation through, *inter alia*, advocacy, litigation and monitoring at the national, regional and international levels (Yamin, 2008).

Accountability through monitoring

Human rights treaty bodies, given an explicit mandate to assess human rights treaty implementation, have become leading institutions of international monitoring (Bayefsky, 2001). In addition to interpreting human rights norms (through general comments, recommendations and statements), treaty bodies hold international legal authority to monitor national efforts to implement treaty obligations (Egan, 2011). Where the treaty monitoring process was long criticised for its procedural inefficiencies – including the absence, lateness or unsatisfactory content of state reporting – the UN has sought to streamline the treaty monitoring process in assessing state implementation of human rights (OHCHR, 2012a). Providing an external check on state efforts to implement human rights obligations, this international monitoring assists states in assessing achievements and recommending reforms (Mechlem, 2009), seeking to facilitate accountability for the progressive realisation of the human right to health (Forman, Caraoshi, Chapman, & Lamprea, 2016).

Treaty bodies monitor state implementation of human rights treaties through the review of state reports, constructive dialogue with state delegations and concluding observations on state obligations (Figure 1).

Following treaty ratification, states are obligated to submit to the treaty body an initial report about national human rights conditions and thereafter submit periodic reports every 5 years on national efforts to implement treaty obligations (O’Flaherty & Tsai, 2012). The treaty body considers these state reports in conjunction with information presented by sources independent of the state, including national human rights institutions (NHRIs), non-governmental organisations (NGOs) and civil society, academic institutions and international organisations. These independent reports – referred to as ‘stakeholder reports’, ‘alternative reports’ or ‘shadow reports’ – often challenge the state report by presenting alternative views on state performance. Engaging thereafter in ‘constructive dialogue’, the state sends a delegation to meet directly with the treaty body – to present the state’s report, respond to questions and discuss implementation of treaty obligations (Egan, 2011).

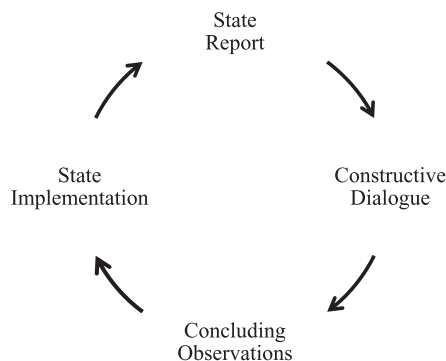


Figure 1. Treaty body monitoring process.

Treaty bodies complete each state assessment by issuing ‘concluding observations’. These concluding observations are comprised of sections that assess both ‘positive aspects’ and ‘principle areas of concern’ in a state’s human rights record. The concluding observations end with recommendations to enhance the implementation of human rights, offering an important interpretive tool for meeting treaty obligations (Connors, 2000; O’Flaherty, 2006). While the issuance of concluding observations brings the formal consideration of a state report to a close, each treaty body employs distinct follow-up procedures in the ensuing years, continuing the process of monitoring state implementation until the next report (Ploton, 2017). With each periodic report building on the concluding observation before it, the process is intended to form a virtuous cycle in each round of monitoring, with these continuing assessments building momentum for the implementation of health-related human rights.

Committee on Economic, Social and Cultural Rights

The CESCR, composed of 18 independent experts, has become the principal human rights treaty body in monitoring state implementation of public health obligations. Operating in tandem with other national, regional and international monitoring institutions – including the Human Rights Council’s Universal Periodic Review (UPR) of all human rights – the CESCR monitors the implementation efforts of its 165 states parties on a range of economic, social and cultural rights, facilitating accountability for the seminal right to health obligations that states have assumed by ratifying the ICESCR (Meier & Brás Gomes, *forthcoming*). Such external monitoring has particular relevance to the realisation of the ICESCR (Alston, 1987), which obligates a state to take steps only ‘to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights’ (UN General Assembly, 1966, art. 2). This ‘principle of progressive realisation’ is a formal recognition that the full realisation of rights will be dependent on financial resources, giving flexibility to states in resource expenditures and necessitating periodic monitoring of progressive implementation efforts (CESCR, 1990).

In structuring state reporting on these implementation efforts every 5 years, the CESCR’s 2008 Reporting Guidelines have established an article-by-article reporting process, including specific indicators for each substantive right of the ICESCR (CESCR, 2008). Specifying what states should report on the progressive realisation of the right to health, examining both the extent and pace of human rights realisation, these Reporting Guidelines direct states in describing their progress to: implement the ICESCR, address issues raised in general comments and respond to previous concluding observations (Coomans, 2009). Yet, with only limited efficacy of these Reporting Guidelines in the evolving content of state reporting to the CESCR (Meier & Kim, 2015), treaty body monitoring mechanisms have not been thoroughly studied to assess their effectiveness in facilitating human rights accountability (Krommendijk, 2015).

Methodology

Investigating monitoring mechanisms for the human right to health, this international institutions research examines the extent to which the CESCR's concluding observations are structuring state public health reporting. The authors hypothesised that the CESCR's concluding observations influence subsequent state reports, as measured by the frequency of indicators of the right to health in consecutive state reports and intervening concluding observations. By examining the association between right to health indicators in state reports and previous concluding observations, this study analyses the influence of treaty monitoring on human rights implementation by examining the changing public health information reported to human rights treaty bodies.

Analytic coding

This study employed analytic coding methods to analyse the content of state reports and concluding observations. Coding allows for the systematic identification of thematic content in a text, providing a means to organise, correlate and analyse themes across a set of documents (Bradley, Curry, & Devers, 2007). Where qualitative coding methodologies have taken root in the public health policy literature – examining, for example, the impact of public health laws on public health outcomes (Burriss et al., 2010) – these empirical methodologies are only beginning to be applied to analyse human rights for global health (Heymann, Cassola, Raub, & Mishra, 2013).

With a scarcity of cross-national data on human rights practices, this study compiled a dataset of state human rights reports and CESCR concluding observations, coding these documents based upon normative indicators of the human right to health. Although few have studied the contemporary practice of the CESCR, this treaty body provides an unparalleled perspective on human rights treaty monitoring for public health (Potts & Hunt, 2008). Influential in interpreting state obligations under the right to health, a pilot study confirmed that the CESCR is the human rights treaty body to which states report the vast majority of their public health implementation efforts.

The authors worked with a team of five researchers (the research team) to compile a comprehensive collection of state human rights reports and CESCR concluding observations, beginning with the 164 state reports submitted to the CESCR between 2001 and 2013. To identify thematic changes across periodic reports, the dataset of relevant reports was winnowed to the 38 states that had reported twice in the 13-year timeframe.¹ In addition to these 76 state reports, the study collected the intervening 38 CESCR concluding observations, allowing for an examination of the influence of concluding observations on subsequent state reports (Figure 2).

These state reports include 15 low- and middle-income and 23 high-income countries (as classified by the World Bank's standards on GNI per capita), allowing for the comparison of countries by relative level of wealth.

To code the documents in this dataset, a codebook was developed to capture indicators of the right to health. Including the public health topics and human rights norms to be examined in each state report and concluding observation, these deductive codes (indicators) reflect topical issues of public health (derived from the WHO classification of health topics) and the following norms of the human right to health (derived from CESCR general comments) (Table 1).

The full codebook included these codes, a brief definition of each code and examples of coded text (MacQueen, McLellan, Kay, & Milstein, 1998). Three experts at the intersection of global health and human rights reviewed the codebook for its accuracy in capturing right to health indicators, and

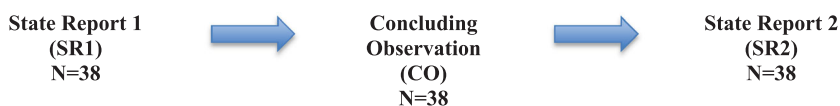


Figure 2. Dataset of state reports and concluding observations.

Table 1. Normative content of the right to health.

Type of Information	Type of Obligation	Normative Attributes (AAAQ)	Human Rights Principles	Population Addressed	Quantitative or Qualitative	Committee Sentiments (applies only to concluding observations)
Structure	Respect	Affordability (economic accessibility and health insurance coverage)	Equality and non-discrimination	Urban	Geographic regions	Quantitative Supportive
Process	Protect	Quality	Participation	Rural	Physically disabled	Qualitative Critical
Outcome	Fulfil	Availability (quantity of facilities, goods and services)	Accountability (includes monitoring)	Women	Mentally disabled	Absent
		Accessibility (physical and information accessibility)	Sustainability	Children	Older persons	
		Acceptability (medical ethics, gender, culture)		Racial/ethnic minorities	Prisoners	
				Migrants	Indigenous persons	
				Refugees	Sexual minorities	
				Vulnerable population		

additional inductive codes were added as health topics were conceptualised through the coding process.

Using ATLAS.ti (version 7.5), the research team examined the right to health section of each state report (ICESCR article 12) and the entirety of each concluding observation, coding documents at the paragraph level (Friese, 2012). Every set of documents was coded independently by two randomly assigned members of the research team (Heymann, McNeill, & Raub, 2014), scrutinising each relevant paragraph to assign one or more codes from the codebook (Figure 3).

To assure consistency in coding designations across coders, the research team was trained together on the human rights norms and public health topics and then met with the lead author on a weekly basis to review the coding of documents and consider missing or misapplied codes (Burla et al., 2008). Facilitating a shared understanding of code definitions, any disagreements among research team members were discussed and resolved, adjusting the codebook to reflect revised indicators and recoding previous documents to assure consistent coding (Heymann, McNeill, & Raub, 2015).

After all of the documents were coded, the authors analysed the frequency with which these coded paragraphs were found in concluding observations and state reports (controlling for the number of paragraphs per report²). The association in the frequency of codes (per paragraph) between the two consecutive state reports (SR1 and SR2) was analysed alongside the frequency of codes (per paragraph) in the concluding observation (CO), thereby examining the hypothesised effect of the intervening concluding observation (CO) on subsequent state reporting (SR2).

23. The Committee is concerned at the inadequate health services and the lack of awareness-raising concerning sexual and reproductive health, as a result of which infant and maternal mortality have not been reduced. It is also concerned at the large number of illegal abortions, which are the principal reason for the high maternal mortality rate in the State party.

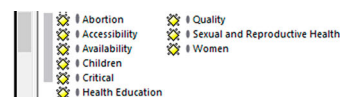


Figure 3. Coded paragraph in ATLAS.ti.

Coding limitations

While coding enables the identification and analysis of the thematic content of the right to health, such methods must account for potential biases in the dataset. It has been well documented that many states are not reporting on-time to treaty bodies,³ creating a participation bias due to an over-sampling of compliant states, and additional research is necessary to understand those states that ratify a human rights treaty but neglect to report to the corresponding human rights treaty body (Hafner-Burton, 2012). In addition, this study hypothesises that the content of state reports is influenced predominantly by previous concluding observations; however, it is possible that state reports could additionally be influenced by unobserved variables, including other treaty body communications, domestic political pressures and civil society advocacy (Moriijn, 2011). Finally, while state reporting may chronicle national efforts to implement rights, there are additional methodological concerns that state self-reporting does not necessarily reflect the actual implementation of human rights on the ground, and additional research will be necessary to examine the links between state reporting and government practice (Hafner-Burton & Tsatsui, 2005). Notwithstanding these limitations, this novel empirical approach demonstrates the potential of human rights monitoring to influence human rights implementation, analyses the influence of treaty body monitoring as a basis for human rights accountability and generates more specific hypotheses for future studies on human rights implementation practices.

Results

The adoption of concluding observations by a human rights treaty body provides an authoritative assessment of implementation expectations for each human right in a given treaty. As such, the CESCR's concluding observations include assessments of the right to health that are either (a) critical of state implementation, (b) reflective of an absence of specific information in a state report or (c) supportive of state human rights efforts. Given the CESCR's monitoring role, it is not surprising that critical observations on the right to health (including observations critical of a state for failing to provide pertinent data) far outweigh supportive observations, with the Committee far more likely to focus its concluding observations on subjects of concern and recommendations for future implementation efforts (Figure 4).

Where these concluding observations are intended to provide a basis for future state reporting, an examination of associations between concluding observations and subsequent state reports provides an understanding of the CESCR's influence on state implementation efforts – and thereby a basis for analysing the effectiveness of treaty monitoring in facilitating accountability for the right to health. This part analyses these thematic associations between concluding observations and state reports, examining the extent to which the CESCR's concluding observations have influenced state efforts to report specific (a) public health topics and (b) human rights norms under the right to health.⁴

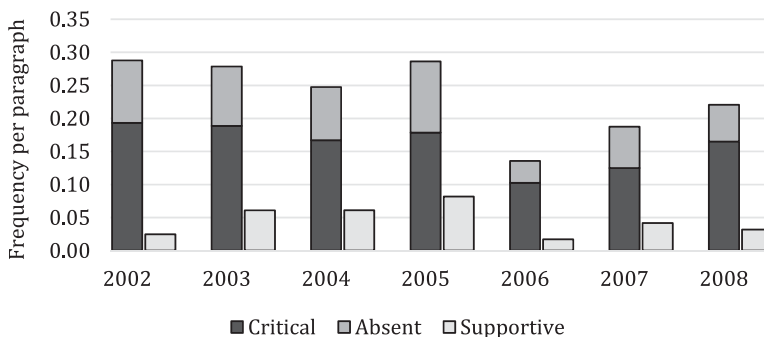


Figure 4. Committee's sentiment in concluding observations.

Public health topics

The implementation of the right to health has become a priority for an increasing number of states since General Comment 14, and states have increasingly discussed public health topics in reporting to the CESCR on their implementation efforts (Jung & Rosevear, 2012) (Figure 5).

The CESCR has addressed a range of public health topics in its concluding observations (Figure 6). Yet, despite increasing evidence of their importance to public health, there are key public health topics to which the CESCR has given negligible attention, including:

- Ageing – which, despite frequent requests for health statistics among ‘older persons’, does not address the particular health concerns inherent in ageing populations (WHO, 2015).
- Health Research & Informed Consent – which could indicate a cloistering of discussion on health research before other treaty bodies (Røttingen et al., 2013).
- Public Health Emergencies & Disaster Relief – which indicates a failure to see health security as relevant to the right to health (Gostin, 2014).

Further, the CESCR has largely neglected intersectional public health issues, avoiding discussion of health in the context of:

- Housing & Health Facilities;
- Labour & Occupational Health;
- Environmental Health.

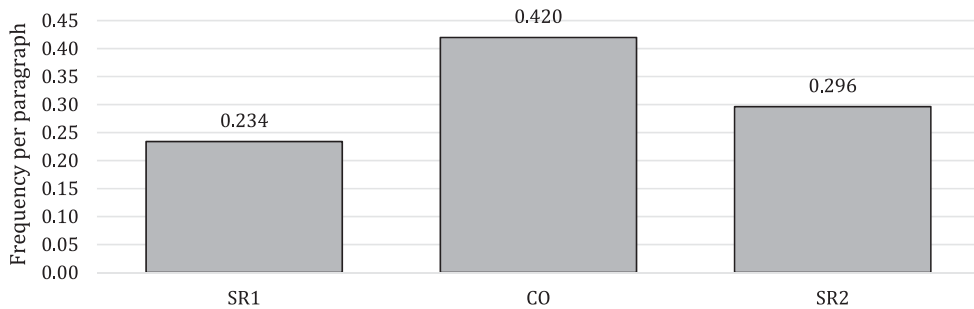


Figure 5. Average mention of health topics.

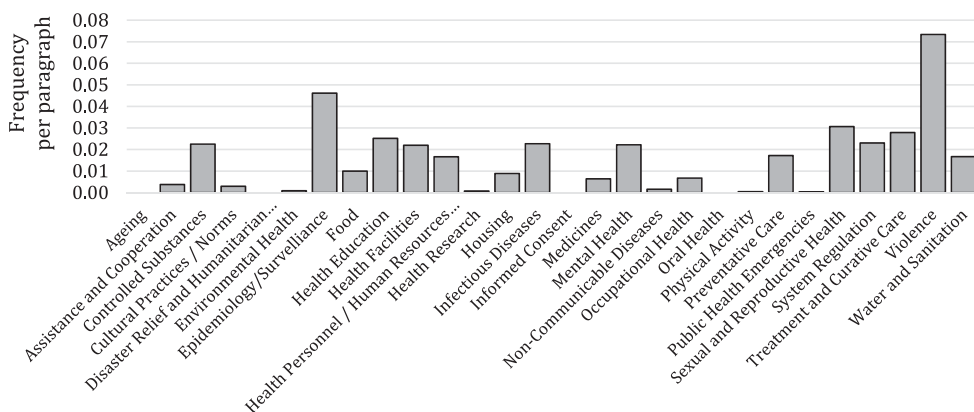


Figure 6. Frequency of public health topics in concluding observations.

Beyond these gaps in monitoring distal determinants of public health, the CESCR has sought to address the proximal determinants of health raised in General Comment 14 and the Committee's Reporting Guidelines, with these recommendations in concluding observations (often critical of state implementation or noting an absence of specific information) finding mixed effects in subsequent state reports, as seen in the summary of all health topics (Table 2) and the specific health topics that follow.

Medicine versus preventive care

In accordance with public health discourse, codified in global health policy in the 1978 Declaration of Alma-Ata and translated into obligations of the right to health through General Comment 14 (Meier, 2007), the CESCR has sought to shift states away from medical treatments and toward preventive care in state reporting (Figure 7).

Reflected in the CESCR Reporting Guidelines' holistic emphasis on 'preventive, curative, and rehabilitative health facilities, goods and services', this shift toward preventive care has been observed in the Committee's concluding observations and subsequent state reporting, as seen in:

'The Committee urges the State party to continue its prevention and care efforts in the field of health by providing sexual and reproductive health services to the population, with particular emphasis on those for women, young people and children' (CO Brazil – 2003).

'[A] Program on Health and Prevention in Schools was introduced in 2004 to provide preventive education and to orient young people, teachers, parents, and communities, with a view to reducing the rate of infection of young people in the 13–24 age bracket with HIV and other sexually transmissible diseases. In addition to disseminating sexual and reproductive health concepts among students, the program is aimed at widening the debate about issues related to human rights, gender, discrimination and prejudice, pregnancy, violence, and drugs, as well as providing ongoing training of teachers and health professionals' (SR Brazil, 2007).

The CESCR has proven effective in pushing states toward implementing the right to health through preventive care, even as states have been hard-pressed to provide data on the outcomes of these preventive efforts.

Infectious versus non-communicable disease

Although global health governance has increasingly focused on non-communicable diseases (NCDs) (Beaglehole et al., 2011; Huckel Schneider, Gillespie, & Thow, 2017), which have rapidly overtaken infectious disease in morbidity and mortality and recently become an issue of human rights concern (Ferguson, Tarantola, Hoffman, & Gruskin, 2017), this attention has not translated into state reporting or concluding observations (Figure 8).

When the CESCR has addressed any NCD harms, it has been confined to specific determinants raised in the CESCR Reporting Guidelines – 'the abuse of alcohol and tobacco, and the use of illicit drugs and other harmful substances' (CESCR, 2008) – as seen where:

The Committee recommends that the State party educate young people about the risks of drug abuse and of tobacco and alcohol consumption, to intensify its campaigns against such abuse and excessive consumption, as well as its information campaigns for children, parents, teachers and the general public, and to ensure that adequate counselling services are available to all persons affected by drug, tobacco or alcohol addiction (CO Austria, 2006).

This limited focus on NCDs has neglected necessary policy efforts to address the social determinants of obesity and the attendant pathologies of diabetes, hypertension and cardiovascular disease (Popkin, Adair, & Ng, 2012). Given that the Committee has given only negligible attention to NCDs in its concluding observations, with the Reporting Guidelines focussing on measures to implement 'strategies of infectious disease control', it is not surprising that this lack of attention is reflected in a relative decrease in states' already paltry attention to these expanding harms.

Table 2. Trends across state reports following ‘critical or absent’ sentiment in concluding observations.^a

	Assistance and Cooperation	Controlled Substances	Cultural Practices / Norms	Environmental Health	Epidemiology/Surveillance	Food	Health Education	Health Facilities	Health Personnel	Health research	Housing	Infectious Diseases	Medicines	Mental Health	Non-Communicable Diseases	Occupational Health	Physical Activity	Preventative Care	Public Health Emergencies	Sexual and Reproductive Health	System Regulation	Treatment and Curative Care	Violence	Water and Sanitation	
Albania					-		+	+	+					+				+		+	+	+	+		
Austria		+						+						+									-		
Azerbaijan		+			+	-	+	+	+		+	+		-				+		+	+	+	+	+	-
Belgium					-			+										+					-	-	
Benin			+				+	+	+											+	-		-	-	-
Brazil					-	-	-	-	-		-	-						-		+		-	+	-	-
Canada					+																		+	+	
Denmark		-			-				-					-									+	+	
Ecuador				-	-		-				-		+			-	-	-		-	-	+	-		
El Salvador					+		+	+				+	+					+		+	+	+	+	+	
Estonia	-	+		-	+		+	-				+						+		+		+	+		
Finland		+			+									+				+					-		
France		-			+			+						+				+							
Guatemala		-			-	-	-	-			-			-						-			-	-	
Iceland		-			-											-							-	-	
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Italy					+		+					+			-								+		
Kenya			-		-	-	-	+	+			+	-	-	-			+		+	+	+	+	+	-
Kuwait	-				-		-		+			-				-				-	-	-	-	-	
Moldova		+			+		+	+				+		+						+			+		
Monaco		+																+		+			+		
Morocco					+											-				-	-	-	-	-	-
Nepal			-		-	-	-	-	-					-		-		-		-	-	-	-	-	-
Netherlands					+															-			-	-	
New Zealand					+									+				+				-	-	-	
Norway					-	-		-	-					-									+	-	
Paraguay					+	-	+	+	+			+		+				+		-	+	+	+	-	
Poland	-				-		-	-				-		-						-	-	-	-	-	
Russia		-			+	-	+	-					+					+	+	+		-	+	+	-
Serbia		-			-		-	-			-	-		-						-		-	-	-	-
Slovakia	-	+					+	+						-				-					+		
Slovenia					+		-	-	+											-			-	+	
Spain		+			+															-			-	-	
Sweden		-			+	+	+					+		+				+		+	+	+	+	-	
Tajikistan		-			-		+	+	+			+	-	+		-		+		+		-	-	-	-
Ukraine		+			+	+	+	-	-			+	+		+			-					-	-	-
United Kingdom		-									-	+		+									+	-	
Yemen	-		-		-	-	-			+	-	-										-	-	-	-

^aA positive relationship between reporting trends within state reports and the sentiment expressed by the CESCR implies that the reporting state addressed a given health topic more often than in the previously submitted state report after the CESCR has made critical comments or noted that information was absent on the given health topic. A negative association shows that the country has paid less attention to a given health topic after the CESCR has made critical or absent remarks about it.

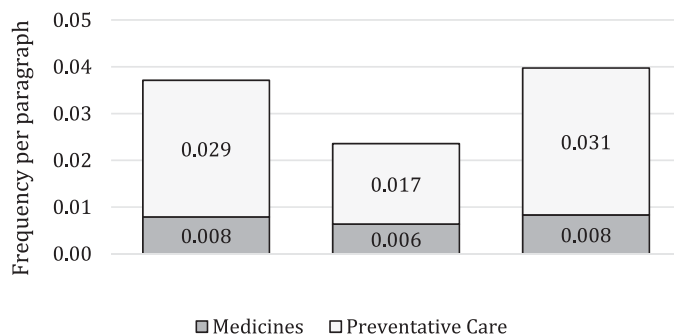


Figure 7. Frequency of medicines and preventative care.

Human resources for health

Human resources are necessary to assure health service coverage to meet public health challenges (Campbell et al., 2013). Seeking a more equitable distribution of the global health workforce, health education provides the skills essential for health professionals to address changing health needs (Crisp & Chen, 2014), with the CESC Reporting Guidelines requesting reporting on measures to ensure ‘adequate training of health personnel’ (CESCR, 2008). Nevertheless, despite strong CESC focus on trained health workers in concluding observations, especially in recommending measures to developing countries, there has been little attention to these issues among states (Figure 9).

The Committee has repeatedly drawn attention to the lack of human resources for health in the developing world. When the Committee mentions human resources in its concluding observations, it mentions it together with health education 35% of the time, as seen in:

The Committee is concerned about the high maternal, infant and under-five mortality rates, the lack of adequately equipped maternal health care facilities and skilled birth attendance, especially in the North Eastern and Coastal Provinces, and de facto discrimination against poor women, older women and women with HIV/AIDS in access to maternal health care (art. 12) (CO Kenya, 2008).

Inapposite to this attention, only high-income states have responded by raising this issue in subsequent reporting on the right to health, as seen in:

The Swedish Government appropriated special funding for 2013 and 2014 to develop course activities for a physician’s postgraduate clinical training to become a specialist, which is expected to have a positive impact on the supply of specialists. Among other things, a project has been commissioned to develop and strengthen courses for qualifying physicians as specialists in general psychiatry, as this is a specialty within which there has been a shortage of specialists for some time (SR Sweden, 2013).

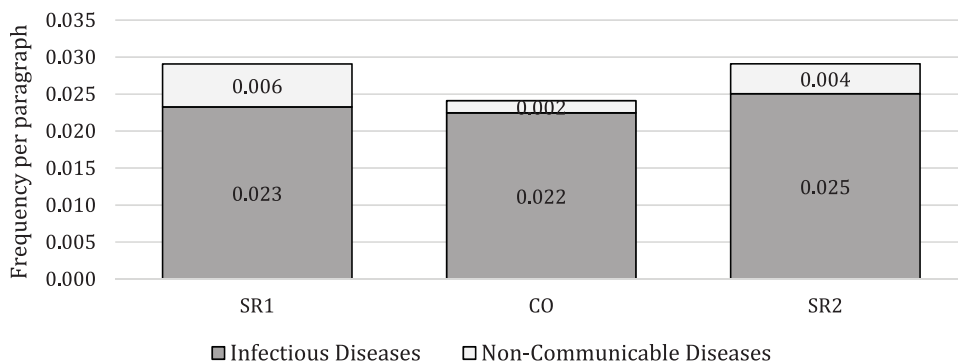


Figure 8. Frequency of infectious diseases and NCDs.

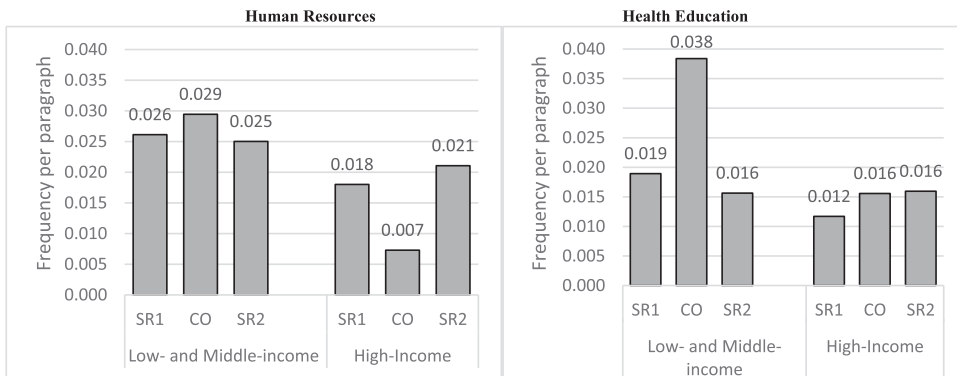


Figure 9. Frequency of human resources and health education.

Without effective monitoring of human resources for health, it is unlikely that states will undertake essential policy reforms to build the health workforce necessary to realise the right to health.

Mental health

Mental health has long been approached as central to the right to health – if not part of its core content (Gable & Gostin, 2009). As a result, the CESCR has addressed mental health frequently in concluding observations; however, the effect of this attention is seen only in subsequent reports from low- and middle-income states (Figure 10).

Although the CESCR Reporting Guidelines limit focus on mental health to reporting on measures to ‘ensure adequate treatment and care in psychiatric facilities for mental health patients’, the CESCR has gone beyond this focus on mental health facilities, as seen in concluding observations and subsequent state reporting:

The Committee encourages the State party to consider alternative forms of mental health treatment, including outpatient treatment (CO Albania, 2008).

Pursuant to the legal frame, the mental health reform continues, aimed at reducing the number of beds in the psychiatric hospitals and the opening of daily community centers for mental health in the districts with psychiatric hospitals and cabinets, as well as in opening protected homes for chronic patients. This reform is designed to observe their rights, improve the living conditions and rehabilitate them to return to their families (SR Albania, 2010).

Highlighting the ability of the CESCR to move beyond its Reporting Guidelines, this monitoring focus on inclusion, non-discrimination and community-based rehabilitation matches public health evidence and reflects a disability rights approach to health (Perlin, 2012).

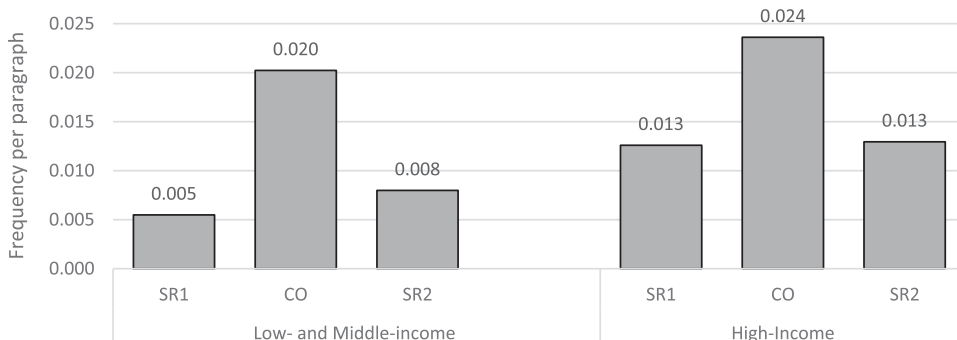


Figure 10. Frequency of mental health by development status.

Human rights norms

As part of a rights-based approach to health, the right to health has distinct normative attributes and principles that can be identified, delineated and examined in state efforts to implement the ICESCR and state reporting to the CESCR (Hunt, 2016). However, when compared with public health topics – where the focus on health increases in the second reporting cycle (often in correlation with the themes raised in the previous concluding observation) – there has been far less change in human rights norms over time.

Normative attributes

Where the CESCR's General Comment 14 introduced an AAAQ indicator framework (focused on availability, accessibility, acceptability and quality) for the right to health, future general comments expanded this focus to account for affordability (as derived from 'economic accessibility'), delineating normative attributes for health wherein:

- **Availability** refers to a sufficient quantity of underlying determinants of health, public health, and healthcare facilities, goods and services, as well as programmes (CESCR, 2000);
- **Accessibility** refers to obligations of physical and informational access, including that '[h]ealth facilities, goods and services must be within safe physical reach for all sections of the population' (WHO, 2002);
- **Acceptability** refers to respect for 'the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned' (CESCR, 2000);
- **Affordability** refers to 'ability to pay for services without financial hardship'. Influenced by the health financing system and household income, it 'takes into account not only the price of the health services but also indirect and opportunity costs' (Evans, Hsu, & Boerma, 2013);
- **Quality** refers to medically appropriate facilities, goods/services, and programmes, including 'skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation' (CESCR, 2000).

In the decade following the adoption of General Comment 14, however, an examination of state reports supports early fears that this approach lacked definition in framing the progressive realisation of the right to health (Figure 11). Although low-, middle- and high-income countries approach these normative attributes with approximately equal frequency, the CESCR is far more critical of these normative attributes when assessing developing countries. As seen in the context of affordability, the CESCR is more than three times as likely to address this issue in the concluding observations of low- and middle-income countries despite increasing inequality (and thus decreasing affordability) in high-income countries (Chapman, 2014).

Type of information

The types of information reflective of the implementation of human rights are categorised through a specific 'structure–process–outcome' typology, with this framework monitoring the links between policy cause and social effect by examining how outcome measures are correlated with changes in structure and process.

- **Structure** – reflecting commitment to rights through legal instruments (in the constitution and domestic legislation) necessary for facilitating realisation of rights (Hunt, 2006)
- **Process** – capturing government conduct (in policies, strategies, programmes, interventions, budgets and activities) to implement state obligations (Rosga & Satterthwaite, 2009)
- **Outcome** – measuring results (in individual health and population-level public health data) on the actual enjoyment of rights (OHCHR, 2008).

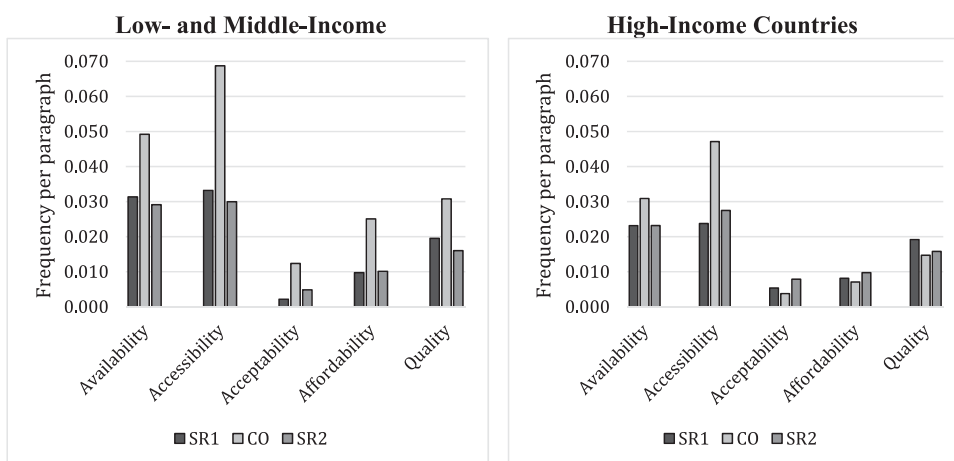


Figure 11. Frequency of normative content by development status.

The UN adopted this tripartite typology to focus states on incremental implementation efforts that could be taken to progressively realise rights and that could be assessed individually by human rights treaty bodies. Recognising that realisation of the right to health depends on legal reforms and resource allocations (WHO, 2017), a focus on outcomes alone provides insufficient information about human rights implementation, and the CESCR has remained committed to monitoring the structures and processes that underlie health outcomes.

This focus in concluding observations has had a dramatic effect on state implementation, with states deemphasising outcomes in subsequent reporting and creating quantitative measures to report on processes relevant to health systems (Table 3). Where the right to health has been incorporated in an increasing number of national constitutions, these new constitutional reforms have supported state efforts to expand quantitative reporting on processes to implement human rights obligations, highlighting the development of new health-related ministries, budgets and policies (Kavanagh, 2016).

Type of obligation

All human rights are seen to possess three kinds of obligations:

- Respect – refrain from interfering with the enjoyment of the right
- Protect – prevent others from interfering with the enjoyment of the right
- Fulfil – adopt appropriate measures towards the full realisation of the right (CESCR, 2000).

Where the Committee has sought in its concluding observations to focus on state obligations to ‘protect’ health, states have responded (Figure 12).

The Committee has requested that states take steps to ensure that third parties do not interfere with health (whether through privatised health services, harmful traditional practices or harm to vulnerable populations), and these efforts to protect individuals from non-state actors have led to an increase in state efforts to protect the right to health.

Human rights principles

Crucial to realising all human rights, the UN has described the ‘rights-based approach’ to public policy as a means to address fundamental cross-cutting human rights principles for, *inter alia*, accountability, equality and non-discrimination, and participation (CESCR, 2000).

Table 3. Co-occurrence between type of information and qualitative/quantitative.

	SR1		SR2	
	Qualitative	Quantitative	Qualitative	Quantitative
Outcome	23.8%	32.3%	21.2%	31.1%
Process	16.6%	20.9%	16.6%	24.7%
Structure	3.2%	3.2%	2.9%	3.6%

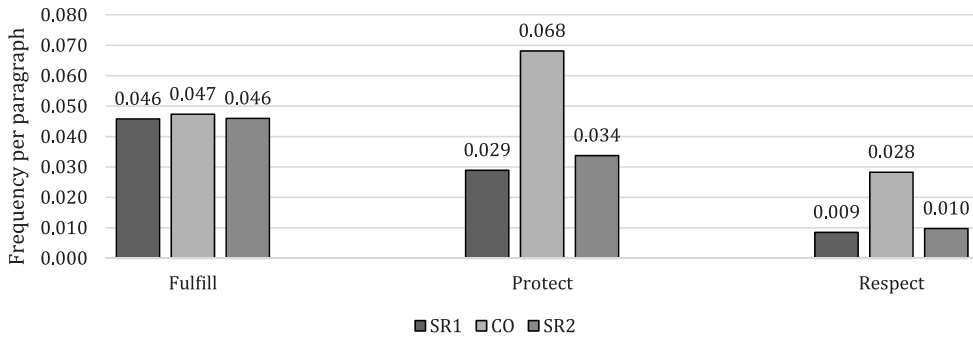


Figure 12. Frequency of type of obligation.

- Accountability – where states must develop domestic monitoring systems to collect accurate data, independent reviews to provide institutional oversight and enforcement mechanisms to ensure corrective action (MacNaughton & Hunt, 2011)
- Non-discrimination and equality – where the ICESCR prohibits ‘discrimination on the grounds of race, colour, sex, age, language, religion, political or health status’ (CESCR, 2000)
- Participation – where community members engage in setting the agenda; identifying and selecting policy options and benchmarks; implementing policies and programmes; and monitoring programme effectiveness (Potts & Hunt, 2009).

These principles pose immediately binding (and often cost-neutral) obligations for the right to health that are not dependent on progressive realisation (Murphy, 2013); yet, states have largely refrained from any discussion of these rights-based principles in their CESCR public health reporting (Figure 13).

To the extent that these cross-cutting principles are seen to apply to the right to health, the CESCR’s concluding observations have focused overwhelmingly on equality and non-discrimination; however, despite frequent CESCR discussion of the importance of disaggregated data to address inequality toward marginalised and vulnerable populations (Langford & King, 2008), states report little information about the inequalities faced by specific populations, limiting the CESCR’s ability to recommend affirmative measures to reduce inequality.

Discussion and conclusion

Human rights treaty bodies are crucial to facilitating accountability for state implementation of the human right to health, but such accountability depends upon state responsiveness to the concluding observations of treaty bodies. With treaty bodies moving toward a ‘simplified reporting procedure’, framing state reporting solely around the treaty body’s ‘list of issues’ and previous concluding observations (UN General Assembly, 2016), the responsiveness to treaty bodies will become more crucial to state accountability in the years to come. Although state reports are largely responsive to concluding observations, these results raise an imperative for the CESCR to develop more effective monitoring mechanisms to assure implementation of the right to health. For the CESCR to monitor

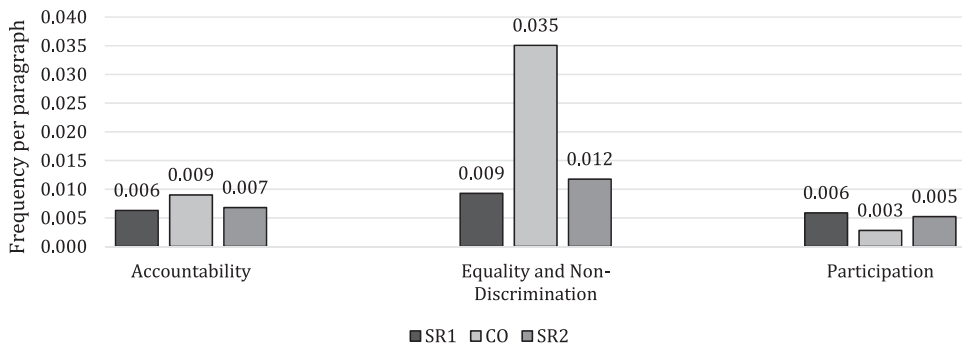


Figure 13. Frequency of human rights principles.

progressive realisation and prevent retrogressive measures in implementing the right to health, there is a need for indicator-based data to assess both public health topics and human rights norms. As part of CESCR efforts to assure that reports meet Committee expectations, revisions of the reporting guidelines could support consistent reporting on those public health data and human rights indicators that reflect the right to health.

Weaknesses of reporting on health topics indicate a need for the CESCR to focus on public health data reflective of realisation of the right to health. As these data are increasingly addressed by public health discourse on social determinants of health (SDH) and universal health coverage (UHC), human rights monitoring requires technical assistance from WHO in providing evidence-based public health information and pertinent health questions to support CESCR monitoring of the right to health (Acharya & Meier, 2016). In examining the relationship between the right to health and other rights under its ICESCR purview, the CESCR can obtain further information from other UN agencies on underlying determinants of health, recognising the role of the SDGs in framing new intersectoral data collection methods (Hawkes & Buse, 2016). Where the CESCR views the right to health in isolation, neglecting the interdependence of rights, these intersectoral issues raise an imperative for states to move beyond the article-by-article reporting process and for the CESCR to examine data from the interconnected sectors that underlie health.

Beyond the health issues addressed by the CESCR, inadequacy in reporting normative attributes of the right to health reflects a failure to frame consistent human rights indicators for state reporting. For monitoring to facilitate human rights accountability, state reports must present consistent indicators that accurately reflect human rights implementation (OHCHR, 2012b). With states increasingly focusing reporting on structure and process indicators, the CESCR has not linked these commitments and efforts to their associated public health results, neglecting consistent outcome indicators that are essential to assessing the progressive realisation of the right to health over time (Meier & Kim, 2015). These empirical results, identifying the public health data and human rights norms addressed in CESCR monitoring, can frame the development of universal human rights indicators that could facilitate accountability for the human right to health.

Notes

1. Although China submitted two reports in this timeframe, this outlier was excluded from the analysis because one of its reports far exceeded the CESCR's guidelines for report length (comprising 1218 paragraphs, compared to an average of 483 paragraphs among all other state reports).
2. The frequency of codes is divided by the number of paragraphs in each of the respective state reports, ensuring comparability across reports where the number of paragraphs differs across countries.
3. Seeking to alleviate this concern for non-reporting states in the years to come, the UN High Commissioner for Human rights recently 'exposed' those states that are delinquent in their reporting to treaty bodies and committed to making this information public.

4. While this article analyses select associations between concluding observations and state reports, the full dataset of codes for this project can be found at http://bmeier.web.unc.edu/files/2017/04/Right-to-Health_Monitoring_Dataset_04022017.xlsx, and the authors encourage other researchers to identify additional correlations across right to health indicators that may have been overlooked in the present analysis.

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