MODULE 14

THE RIGHT TO HEALTH

USING MODULE 14 IN A TRAINING PROGRAM

The Purpose of Module 14

The purpose of this module is to provide an overview of the guarantees related to the right to health.

The module

- *looks at the development of the concept of the right to health;*
- *enumerates international, regional and national standards;*
- *analyzes the state's obligations; and*
- *considers international and other mechanisms to protect the right.*

Why the Right to Health?

Health and well-being are deeply personal matters. Nothing is more intimate than the experience of conceiving and bearing a child, and giving birth to a unique human being; none of us can live another's fear or pain; and death itself is something we cannot share, however real the grief we suffer.

And yet, it is precisely when we or those close to us face illness or chronic suffering that we perceive that health is in reality a very public issue. Policies which dictate what level of health care provision is guaranteed, what kinds of service will be offered, how priorities are established between competing claims, where resources are concentrated, and what alternatives are available all become far more immediate when they affect us or our loved ones. Facing a particular health related condition, and then being on the receiving end of the decisions or prejudices of others-be they health professionals, religious authorities, family members, neighbours, employers or insurance companies-is something that often gives us a new awareness

of how limited is our capacity to control some of the most central aspects of our lives. It gives us an insight into what exclusion feels like.

Disempowerment and exclusion are caused by a similar combination of personal experience and circumstances on the one hand and the social and political context on the other . . . At one end of the spectrum, we see the importance of the macroeconomic and ideological settings. Economic policies that result in the underfunding of public services and the fragmentation of the regulatory role of government tend to reduce the threshold of what is considered an acceptable minimum standard of health-care provision for the population at large. Access to health care becomes dependent on the individual's capacity to pay; patients are turned from citizens who have rights and responsibilities into clients or consumers . . . The question of financing health care may thus be posed as a pseudo-technical one; what kinds of cost-recovery and insurance mechanisms "work", and in what circumstances? The goal of "Health for All by the Year 2000" is eroded into one of "health for those who can pay today".

Current trends suggest that "the enjoyment of the highest attainable standard of health" which WHO describes as "one of the fundamental rights of every human being" is seen almost as a by-product, something that will trickle down to the bottom some time in the future. There is a long way to trickle before this fundamental right reaches those who are destitute (currently one fifth of the human race), those who survive precariously in the informal sector, or those whose access to health care is limited by their age or their disabilities, or by armed conflict. And while seven out of ten of the world's poorest people are female, women's health needs are widely neglected, whatever their background. Yet, if development is not for health, what is it for-and who can expect to enjoy it? [1]

Development of the Concept of the Right to Health

Traditionally health was seen as falling within the private, rather than public, realm. Health was also understood as the "absence of disease." The first laws containing health-related provisions go back to the era of industrialization. The Moral Apprentices Act (1802) and Public Health Act (1848) were adopted in the United Kingdom as a means of containing social pressure arising from poor labor conditions. The 1843 Mexican Constitution included references to the state's responsibility for preserving public health. [2]

The evolution towards defining health as a social issue led to the founding of the World Health Organization (WHO) in 1946. [3] With the emergence of health as a public issue, the conception of health changed. WHO developed and promulgated the understanding of health as

"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [4] It defined an integrated approach linking together all the factors related to human well-being, including physical and social surroundings conducive to good health.

With the establishment of WHO, for the first time the right to health was recognized internationally. The WHO Constitution affirms that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Over time, this recognition was reiterated, in a wide array of formulations, in several international and regional human rights instruments, which include:

- Universal Declaration of Human Rights (art. 25)
- American Declaration on the Rights and Duties of Man (art. 33)
- European Social Charter (art. 11)
- International Covenant on Economic, Social and Cultural Rights (art. 12)
- African Charter on Human and Peoples' Rights (art. 16)

Universal recognition of the right to health was further confirmed in the 1978 Declaration of Alma-Ata on Primary Health Care, in which states pledged to progressively develop comprehensive health care systems to ensure effective and equitable distribution of resources for maintaining health. They reiterated their responsibility to provide for the health of their populations, " which can be fulfilled only by the provision of adequate health and social measures." [5] The Declaration develops the bases for implementing primary health care systems, which have implications for the observance of the right. While this instrument is not binding, it does represent a further commitment on the part of states in respect of the right to health, and establishes the framework for an integrated policy aimed at securing its enjoyment.

In the context of the Alma-Ata Conference, WHO designed the plan, *Health for All by the Year 2000*, [6] which consists of a series of goals and programs to achieve minimum levels of health for all. Nonetheless, in a context in which health problems associated with poverty and inequity continue to pose the main obstacles to attaining minimal levels of well-being for most of the world's population, the failure to achieve these goals points to the need to rework strategies.

Promoting health, one of the fundamental aspects of primary health care, has been addressed independently by four successive conferences, the first in Ottawa, Canada, in 1986 [7] and the most recent in Jakarta, Indonesia, in 1997. The Declaration of Jakarta includes an updated conceptualization of health and identifies the requirements for its attainment as we head into the next century. These include "peace, housing, education, social security, social relations, food, income, women's empowerment, a stable ecosystem, the sustainable use of resources, social justice, respect for human rights, and equity. Above all else, poverty is the greatest threat to health." [8]

Other relevant international initiatives in recent years related to health are the Program of Action of the International Conference on Population and Development (Cairo, 1994), which encompassed three goals related to reducing infant and maternal mortality, and guaranteeing

universal access to reproductive health and family planning services; and the Platform of Action of the Fourth World Conference on Women (Beijing, 1995), which adopted five strategic objectives aimed at improving women's health worldwide.

Health as a Human Right

International standards

Article 25 of the UDHR emphasizes recognition of the right of all persons to an adequate standard of living, including guarantees for health and well-being. It acknowledges the relationship between health and well-being and its link with other rights, such as the right to food and the right to housing, as well as medical and social services. It adopts a broad view of the right to health as a human right, even though health is but one component of an adequate standard of living.

In article 12 of the ICESCR, states parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." That article identifies some of the measures the state should take "to achieve the full realization of this right."

Articles 23 and 24 of the CRC recognize the right to health for all children and identify several steps for its realization. Similarly, CEDAW establishes the obligation to adopt adequate measures to guarantee women access to health and medical care, with no discrimination whatsoever, including access to family planning services. It also establishes the commitment to guarantee adequate maternal and child health care (art. 12[2]).

Reproductive Rights and Reproductive Health

Reproductive rights are considered by many women as being at the very core of women's rights. Throughout history, women's reproductive functions have been used to control women themselves. If we examine why women are denied numerous life opportunities; why women are stopped from attending school once they attain puberty; why they are not allowed to move around freely; why they are restricted from taking up employment or from pursuing a career; why they are married off early without a say in the choice of the partner, we return again and again to the same answer-because women have bodies that can be impregnated.

The meaning of reproductive and sexual rights that has evolved over the years is the right to manage one's fertility safely and effectively by conceiving when one desires to, terminating unwanted pregnancies and carrying wanted pregnancies to term; the right to express one's sexuality free of disease, violence, disability, fear, unnecessary pain or death associated with reproduction and sexuality; and the right to social and economic and political conditions that make these possible.

It is important to clarify that reproductive rights and reproductive health are not the same. Reproductive health is only a small component of reproductive rights. Further access to reproductive health services is only one part of the right to reproductive health, just as access to health services is only one aspect of the right to health. For women to have good reproductive

health they have to have good general health and the physical, economic and social conditions that make possible good health overall. 9

Numerous other instruments also provide for the right to health. These are: the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention relating to the Status of Refugees, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the Geneva Conventions, the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, the Standard Minimum Rules for the Treatment of Prisoners, the Declaration on the Rights of Mentally Retarded Persons, the Declaration on the Rights of Disabled Persons, and the Declaration on the Rights of AIDS Patients.

Mental Health

"Mental illness, in its broadest sense, is one of the commonest afflictions affecting the human race. The World Bank report on health and development (1993), though criticised for the unreliability of some of its data, identified 'neuropsychiatric' disease as the second-most important non-communicable cause of disability in the developing world. Of these diseases, depression was the single most important diagnosis. The report emphasises an aspect of health which is intimately related to a community's overall health status and development and which has been ignored by development agencies and health ministries faced with the pressing claims of communicable diseases. However, it is impossible to separate the mental and spiritual components of health from physical illness, in particular when dealing with chronic illness and maternal and child health problems. It is likely, and desirable, that future health-related development work will, and should, include mental health among its priorities."10

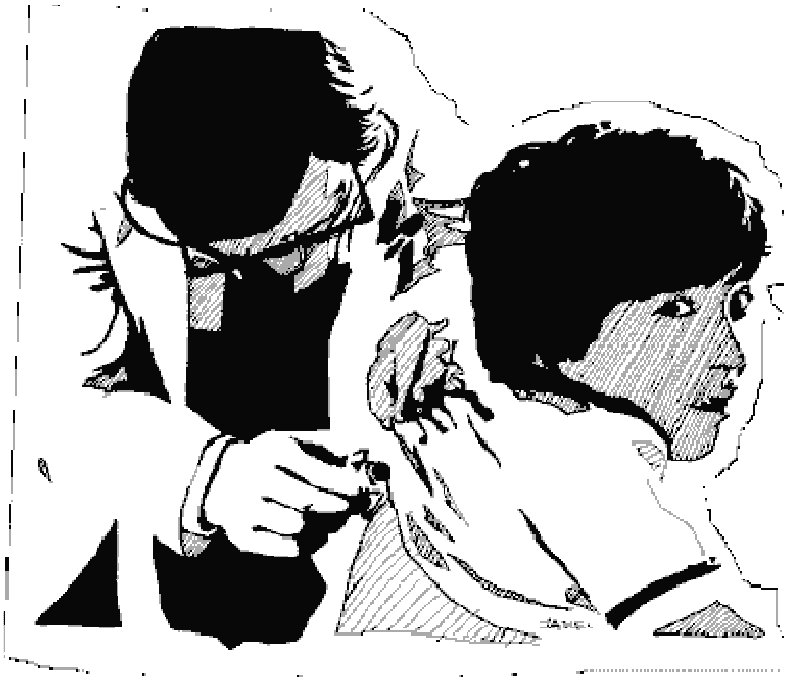
Regional Standards

The Inter-American System

Article XI of the American Declaration on the Rights and Duties of Man establishes the right to the preservation of health through sanitary and social measures (food, clothing, housing, and medical care), while it conditions its implementation on the availability of public and community resources.

Article 34 of the Organization of American States' Charter stipulates, as among the goals for contributing to the integral development of the person, access to knowledge of modern medical science and to adequate urban conditions. The American Convention on Human Rights alludes indirectly to the right to health when it refers in article 26 to the commitment of states parties to take measures to guarantee "the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter."

The Additional Protocol of San Salvador in article 10 explicitly sets forth the "right to health" for all individuals. It lists six measures that should be taken by states parties to guarantee this right, including the development of universal primary care networks. In addition, article 11



guarantees the right to a healthy environment. Nonetheless, the Protocol rules out the possibility of submitting individual petitions before the supervisory organs of the Inter-American system with respect to the right to health.

European System

Article 11 of the European Social Charter refers to the right to protection of health, for the attainment of which it stipulates health promotion, education and disease prevention activities. Paragraph 13 of the first Part guarantees access to social and medical assistance to those without adequate resources. Similarly, article 3 of the Convention on Human Rights and Biomedicine enshrines equal access to health care.

African System

Article 16 of the African Charter on Human and Peoples' Rights enshrines the right to the highest possible level of health, to which end "necessary measures" will be taken, while also guaranteeing medical services in case of illness. The African Charter on the Rights and Welfare of the Child also includes recognition of the right to health.

Domestic recognition 11

The right to health was gradually incorporated in domestic law as of the first half of the twentieth century. For example, the 1925 Chilean Constitution explicitly enshrines the right to health, distinguishing between guarantees for ensuring the well-being of the individual and for attaining public health. As of now, a substantial number of states with civil law systems have incorporated the right to health in their constitutions, often defined as the right to protection of one's health, or establishing a clear role for the state in health policy. In the case of Haiti, the right to health is directly related to the right to life in article 19 of the Haitian Constitution: "The state has the imperative duty to guarantee the right to life, health, and respect for the person." In addition, article 23 establishes the obligations to guarantee the necessary resources to the entire population to protect and regain their health by having an adequate health-care delivery system.

Though it is not common, other countries give constitutional rank to a series of measures aimed at protecting health. In the Constitution of Panama, for example, article 105 enshrines the right to health and the state's responsibility to protect it, while article 106 makes reference to the right to food, education in health, and maternal and child health care, among other things. Article 70

of the Constitution of Hungary, in its first paragraph, sets forth the right to the highest possible level of physical and mental health, while the second paragraph lists four areas of responsibility. Article 27 of the Constitution of South Africa includes the right to health care, food, water and social security. It sets forth "the right to have access to" health services, including reproductive health care, and prohibits the denial of emergency assistance.

Countries whose legal systems are based on common law generally do not provide constitutional guarantees regarding the right to health, though implicit references to public responsibilities for health can be found in the preambles to many constitutions, and in some of the content regarding social policy. In those countries legal recognition of the right to health usually needs to be sought in the decisions of the courts, which may affect the right in one way or another, given that it is grounded essentially in the case law. The United States, for example, does not include any reference to health in its Constitution, yet judicial decisions can be found regarding the state's responsibility to regulate health or its duty to ensure equal access to the beneficiaries of the health and welfare systems. In other countries, reference to health is developed in negative terms, when the constitutions or laws list the limitations that may apply to certain civil and political rights for public health reasons (e.g., as in Barbados), while pointing out the competence, not to say obligation, of the state in respect of health-related matters.

At the same time, practically all the countries with socialist constitutions incorporate the right to health as a fundamental right, along with all other economic, social and cultural rights. In the Constitution of Cuba, article 49 sets forth the right to health care and protection, and establishes the obligation on the state to maintain and provide for a universal and free public health system through educational and preventive programs.

Indivisibility and Interdependence

Right to food: Nutrition programs and provision of food are substantial components of primary health care strategies. In article 24(2)(c) of the CRC and article 12(2) of CEDAW respectively, the right to food is considered to be part of the right to health of both children and women. According to the CESCR's General Comment 12, national strategies on the right to food need be developed in coordination with the development of health measures, among others (para. 25). (See Module 12 on the right to food.)

Right to a healthy environment: Article 12(2)(b) of the ICESCR specifies the environment as one of the areas for state intervention in the realization of the right to health. This provision has traditionally been interpreted as relating simply to occupational health, but in state reporting to the CESCR, it is increasingly being considered as relating to all environmental issues that affect human health. Primary health care strategies include access to clean drinking water and sewage services, and preventive health programs should include control over human activities that may expose people to environmental hazards detrimental to their health. 12 (See Module 15 on the right to a clean and health environment.)

Right to adequate housing: General Comment 4 on the right to adequate housing links the availability of basic services, such as drinking water, housing conditions that protect individuals from health hazards, the availability of health care services and freedom from health-related

environmental risks as core elements of the right (para. 8). WHO has identified housing conditions as the environmental factor having the most relevant impact on the prevalence of epidemiological diseases. (See Module 13 on the right to adequate housing.)

Right to education: Realization of specific core elements of the right to health has as a pre-requisite fulfillment of a basic right to education for all. In addressing the child's right to health, article 24(2)(e) of CRC links that right to the right to education and thereby access to basic knowledge about children's health. Primary health care, in general, includes a need for education on prevailing health problems and methods for preventing and controlling them. (See Module 16 on the right to education.)

Right to work and rights at work: The right to work is closely related to the right to adequate living conditions. The latter in turn is essential to health. In addition, ICESCR article 12(2)(c) identifies prevention, treatment and control of occupational diseases as part of the scope of the right to health and article 12(2)(b) refers to industrial hygiene, which requires the adoption of measures for the prevention and control of hazardous conditions in the work place. Approximately seventy 70 ILO conventions address occupational health issues. Among them are Convention No. 155 (Occupational Safety and Health [1981]), Convention No. 161 (Occupational Health Services [1985]) and Convention No. 148 (Working Environment [1977]). (See Module 10 on right to work and rights at work.)

Right to life: While the right to life is usually considered to be offering protection against killing by state actors, in its General Comment 6, the Human Rights Committee considers it desirable for states to adopt "all positive measures to reduce infant mortality and to foster life expectancy, especially by adopting measures to eliminate malnutrition and epidemics.13 In addition, several national constitutions mention the right to health as an essential component of the right to life.

Right to information: Access to adequate information is essential for appropriate health care. Information related to health policies and resources is also necessary to allow for the monitoring of public policies related to health and effective social participation in health-related policy processes. Limburg Principle 76 also mentions that the process of reporting before the CESCR should be publicized in order to allow for public debate and participation. (See Module 3 for further information on the Limburg Principles.)

Physical integrity: Aside from prohibiting the imposition of acts of torture or ill-treatment, article 7 of the ICCPR explicitly prohibits medical or scientific experimentation on human beings without full understanding of the extent of the experiment and prior consent.14 The UN Principles of Medical Ethics relevant to the Role of Health Personnel establish a series of guidelines to guarantee that health personnel will protect prisoners and detainees against any form of ill treatment or punishment.15

Women's Right to Health

Aside from the complexities associated with the right to health in general, consideration of the right to health of women needs to take into account at least two additional dimensions. Women's right to health must be considered from a gender perspective. In addition, the pro-

hibition against discrimination must be kept in mind. Both dimensions are considered in article 12(1) of CEDAW relating to guarantees of access to health services without discrimination, and article 12(2) related to maternal health services. Access to reproductive health services is also referenced in the CRC (art. 24[2][d]).16 (See Module 4 for a fuller discussion.)

HIV/AIDS and Human Rights

The HIV/AIDS epidemic has a number of human rights dimensions. It is essential to examine public health policies and practices affecting HIV/AIDS sufferers to ensure that these policies and practices do not violate right to health provisions. In particular, it is important to consider the potential discriminatory treatment such individuals may suffer. Although there is currently no international covenant imposing specific obligations on states in this arena, the continuous focus on HIV and related human rights issues has resulted in the adoption of many declarations as well as the development of a general consensus on the UN International Guidelines on HIV/AIDS and Human Rights,17 which address the state's role vis-à-vis the epidemic. These varied efforts have also resulted in the creation of a Joint UN Program for AIDS (UNAIDS), which seeks to unite the efforts of several UN agencies and the World Bank in tackling the huge impact of the epidemic. At the domestic level, efforts to stop discrimination and to guarantee access to treatment of people living with HIV/AIDS has led to very significant local jurisprudence related to human rights. (See Venezuela case study below, p. 281.)

The Right to Health of Other Specific Sectors

The following are some specific issues and provisions related to the right to health of specific sectors:

- Prisoners: Rules 22-26 of the Standard Minimum Rules for the Treatment of Prisoners refer to health services in prison, minimum health entitlements of prisoners and the general duties of doctors assigned to penitentiary establishments.18
- Disabled persons: The UN Declaration on the Rights of Disabled Persons addresses their rights to health care and rehabilitation services.19 In addition, ICESCR General Comment 5 is devoted to disabled persons, and establishes the obligation to adopt positive measures in order to reduce the structural disadvantages that affect them.20
- Victims of violence: The UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power21 lays out the health and social services provisions that should be available for victims of violence, including psychological assistance.
- Mental health: The UN Principles for the protection of persons with mental illness and the improvement of mental health care establish a series of standards to safeguard the human rights of mentally ill persons, guarantee adequate treatment, care and rehabilitation, and ensure humanitarian and non-discriminatory conditions. The UN Declaration on the Rights of Mentally Retarded Persons sets out the rights of such persons to health care, therapy and education.22

State Obligations

The right to health is formulated in different terms in the various instruments that protect it; in general, one finds a relative degree of commitment. Therefore, the obligations that arise from ratification of these instruments are not easy to determine. At the same time, the CESCR has met to determine the scope of the obligations that arise from the right to health, but has yet to reach sufficient consensus to issue a General Comment. The following are guidelines for defining obligations that arise from the formulation of the right in the various treaties of the UN system.

According to the language of article 12 of the ICESCR, the states parties "recognize" the right of everyone to the enjoyment of health. The second paragraph identifies four areas[23] in which steps should be taken to guarantee full observance of the right:

1. reducing infant mortality and providing for the healthy development of children;[24]

2. improving environmental conditions and closer monitoring of the consequences and working conditions of industry;

3. disease prevention, treatment, and monitoring, including preventive health systems[25] and systems for monitoring occupational health; and

4. basic medical services for the entire population.

The policies of promotion, information and education for health as expressions of states' obligations are present in the preamble of the WHO Constitution and in the CRC (art. 24[2][e]) in relation to maternal and child health.

According to the preamble to the WHO Constitution, adopting social promotion measures is an essential component of states' responsibilities. Access and benefits for all persons to scientific progress and its applications (specifically with respect to health) are set forth in the WHO Constitution and in the ICESCR (art. 15[1][b]).

The WHO has stated that to attain health goals, it is necessary to introduce "adequate legislative provisions. For example, to define the rights and duties of persons with respect to their own health . . . to protect the population from risks in the environment, and to allow the communities to establish and administer their own health programs and services."[26]

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NOTES

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1. Deborah Eade, preface to *Development for Health: Selected articles from Development in Practice,* Oxford, UK: Oxfam (UK and Ireland, 1997), 4-5.

2. The first nation to formally incorporate guarantees for ESC rights was Mexico (1917 Constitution), though no specific mention is made of the right to health.

3. The origins of WHO go back to the various international health conferences held in the nineteenth century, the first in Paris in 1851. The Pan American Health Organization (PAHO, founded in Washington in 1902), the *Office International d'Hygiène Publique* (founded in Rome in 1907), and the International Labour Organization (1919), are its immediate forerunners.

4. Constitution of the World Health Organization, *Basic Documents*, Official Document No. 240 (Washington, 1991). The Constitution of WHO was adopted at the International Health Conference held in 1946 in New York, where it was signed by the representatives of sixty-one states (hereafter coted as WHO Constitution).

5. WHO, Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

6. WHO, *Global Strategy for Health for All by the Year 2000* (Geneva, 1981).

7. First International Conference on Promotion of Health, which issued the Declaration of Ottawa.

8. Jakarta Declaration on Health Promotion (1997). The four conferences referred to were organized by WHO in coordination with various international agencies as well as NGOs. Jakarta was the first to incorporate private actors in the effort to achieve a global commitment.

9. Asian Forum for Human Rights and Development, *Report of a Consultation on Reproductive Rights and Human Rights* (Bangkok, 1997).

10. Vikram Patel et al., "Stressed, Depressed or Bewitched? A Perspective on Mental health, Culture and Religion," in *Development for Health*, note 1 above.

11. This section is based on the following materials: H. Fuenzalida-Puelma and H. Scholle Connor, eds., *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington, D.C.: Pan American Health Organization, 1989), and Brigit C. A. Toebes, *The Right to Health as a Human Right in International Law* (Intersenti-Hart, Groningen: School of Human Rights Research, 1999).

12. See Convention on the Rights of the Child, *adopted* 20 Nov. 1989, GA Res. 44/25, 44 UN GAOR Supp. (No. 49) at 165, UN Doc. A/44/736 (1989), *reprinted in* 28 ILM 1448 (1989)

(hereafter cited as Child Convention), which in article 24(2)(c) specifically mentions access to drinking water and sanitation measures; see also CESCR, General Comment 4, *The right to adequate housing (art. 11, para. 1 of the Covenant)*(Sixth session, 1991) at para. 8(b), which discusses access to safe drinking water in the context of the right to adequate housing (see pp. 256-61 of this manual for full text of General Comment 4); see also Toebes, op. cit., 256, who analyzes the topic of water and sanitation measures from the perspective of the CESCR's practice of issuing reports.

13. Human Rights Committee, *General Comment 6, Article 6* (Sixteenth session, 1982), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc. HRI/GEN/1/Rev.1 at 6 (1994), para. 5.

14. Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc. HRI/GEN1/Rev.1 at 30 (1994).

15. Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, GA Res. 37/194, Annex 37. UN GAOR Supp. (No. 51) at 211, UN Doc. A/37/51 (1982).

16. Convention on the Elimination of All Forms of Discrimination against Women, article 12, *adopted* 18 Dec. 1979, GA Res. 34/180, 34 UN GAOR Supp. (No. 46), UN Doc. A/34/46 (1980), 1249 UNTS 13, *entered into force* 3 Sept. 1981, *reprinted in* 19 ILM 33 (1980); and Child Convention.

17. International Guidelines on HIV/AIDS and Human Rights, UNCHR Res. 1997/33, UN Doc. E/CN.4/1997/150 (1997).

18. Standard Minimum Rules for the Treatment of Prisoners, *adopted* 30 Aug. 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, UN Doc. A/CONF/611, annex I, ESC Res. 663C, 24 UN ESCOR Supp. (No. 1) at 11, UN Doc. E/3048 (1957), amended ESC Res. 2076, 62 UN ESCOR Supp. (No. 1) at 35, UN Doc. E/5988 (1977).

19. Declaration on the Rights of Disabled Persons, GA Res. 3447 (XXX), 30 UN GAOR Supp. (No. 34) at 88, UN Doc. A/10034 (1975).

20. CESCR, General Comment 5, *Persons with disabilities* (Eleventh session, 1994), U.N. Doc E/C.12/1994/13 (1994).

21. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, GA 40/34, annex, 40 UN GAOR Supp. (No. 53) at 214, UN Doc. A/40/53 (1985).

22. Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, GA Res. 46/119, 46 UN GAOR Supp. (No. 49) at 189, UN Doc. A/46/49 (1991); Declaration on the Rights of Mentally Retarded Persons, GA Res. 2856 (XXVI), 26 UN

GAOR Supp. (No. 29) at 93, UN Doc. A/8429 (1971).

23. ICESCR article 12(2) refers to some of the measures that should be taken. One should expect that an upcoming General Comment will not only define more strictly the resulting obligations, but that it will also expand the number of areas in which state action should have an impact. In this regard, the principles of the CESCR for the submission of reports include a comment regarding article 12: "the specific measures listed under sections (a) to (d) of paragraph 2 are not necessarily exhaustive of the measures that might need to be taken to ensure the progressive realization of the right to physical and mental health."

24. See Child Convention; see also WHO Constitution.

25. See Child Convention

26. WHO, *Global Strategy for Health for All by the Year 2000* (Geneva, 1981), 59