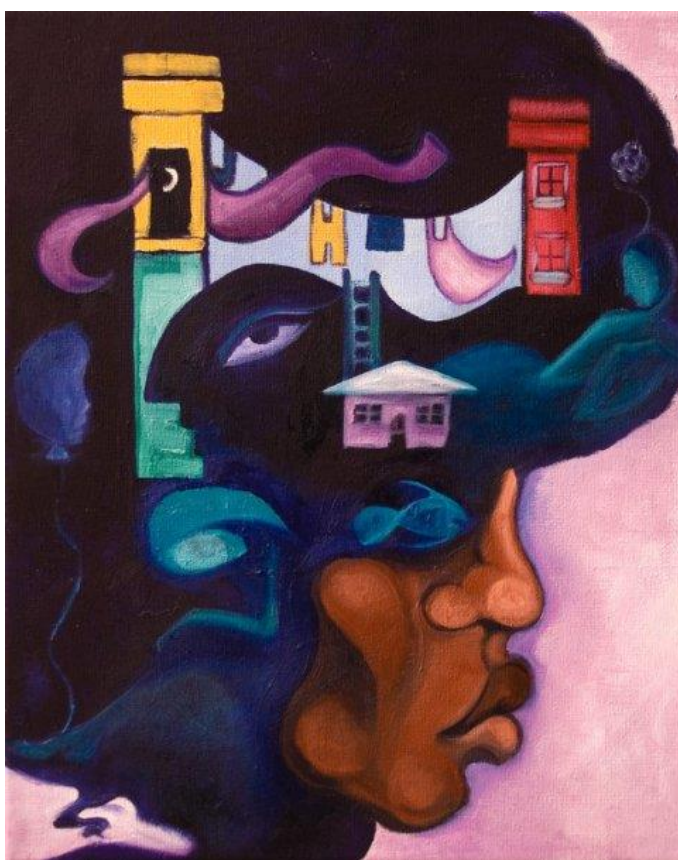


The Right to Health

Proceedings of the
Health and Human Rights Workshops
Wellington and Auckland
New Zealand
February 2012



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Runanga Whakapiki Ake i te Hauora o Aotearoa
Health Promotion Forum of New Zealand

The Right to Health

**Proceedings of the Health and Human Rights Workshops,
Wellington and Auckland, New Zealand
February 2012**

Editor: Carmel Williams

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Tauhi Lelei means Promoting Wellbeing.
Back cover painting: *Inspired* by Viola Bloomfield

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Foreword

It was a privilege and a pleasure to participate in two important health and human rights workshops in New Zealand in early 2012. It was very encouraging that although this was the first time there had been specific health and human rights workshops, they were oversubscribed, dynamic, challenging and deeply engaging events. I thank everyone for their contributions to these days.

We had three objectives in these workshops: to provide a sense of the health and human rights analytical framework that can be used in public health work; to show how this analytical framework can be applied in practical ways; and to identify entry points for applying this in our work. A fourth objective arose throughout the workshops: to ensure rights-based approaches are embedded in our work.

New Zealand is grappling with the same public health issue that occupies and tests health and human rights workers elsewhere around the world: how to ensure there is equitable access to health care and the determinants of health. Case studies in these workshops showed that there is health inequity in New Zealand. Māori and Pacific people and those in families without paid employment do not enjoy the same health outcomes as others. Adopting a right-to-health framework does not make these complex social issues disappear immediately: it is not a magic bullet. However, it does provide a way of addressing public health policy and programme responses so that the needs of people who are most disadvantaged and marginalised are met.

Perhaps the greatest challenge facing all of us working on economic, social and cultural rights is how to make them real for ordinary people, families and communities: in other words, how to *operationalise* these rights, especially for the disadvantaged, including those living in poverty and those experiencing discrimination.

And that is one reason why the Whānau Ora initiative which was discussed at various times throughout these two workshops is important and exciting: it is addressing a wide range of economic, social and cultural rights issues, such as health, housing, education and income security, *in a practical, operational, culturally appropriate way*. Whānau Ora's holistic, participatory, self-managing, operational approach reflects contemporary understandings of economic, social and cultural rights.

One of the great strengths and exciting features of Whānau Ora is that it situates individuals in their whānau, hapu and iwi. It does not treat people as disconnected, isolated, atomised individuals. In other words, it adopts a holistic approach, encompassing the individual and the collective. This is profoundly important. Moreover, this feature is one reason why the concept is attracting international attention. Many societies are searching to find ways of respecting, affirming and balancing both the individual and the collective.

Historically, New Zealand has been a leader in human rights. I believe through Whānau Ora, and the interest shown by the attendance and participation in these workshops, New Zealanders are poised to again offer leadership and example in health and human rights, and improving the health and wellbeing of all its people.

Paul Hunt

Introduction

The Health Promotion Forum of New Zealand, the University of Otago Public Health Summer School and the Centre for Development Studies, University of Auckland, jointly sponsored two workshops on Health and Human Rights in February 2012. We were privileged to have Paul Hunt, a New Zealander, Professor of Law at the University of Essex, UK, and the first UN Special Rapporteur on the Right to Health from 2002–2008, lead these highly engaging and interactive workshops.

The purpose of the workshops was to examine the right to the highest attainable standard of health and to explore its practical application for health workers and policy makers in New Zealand. The three sponsors each brought a slightly different focus to the workshops: the Health Promotion Forum focuses on the health promotion workforce and sector in New Zealand with priorities of improving Māori and Pacific health; the University of Otago Public Health Summer School engages especially with public health policy and practice in New Zealand; and the Centre for Development Studies looks at global health and international development issues from an academic, research and programmatic viewpoint. This diversity was reflected in the participants, and also in the choice of case studies in each workshop.

This publication comprises selected presentations and case studies that reflect the purpose and character of the two workshops. Our intent with this publication is threefold:

1. to provide participants with a record of the workshops and the tools to which they were introduced so they can continue to engage with the right to health in their work;
2. to extend the knowledge shared at the workshop so the right to health is used widely in public health, policy, advocacy or programme work in New Zealand and internationally;
3. to give practical examples of the application of a right to health perspective.

The case studies included in this publication have been selected to illustrate the application of Professor Paul Hunt's right-to-health analytical framework to current issues in New Zealand and the Pacific.

Carmel Williams

Acronyms used in this report

AAAQ	Available, accessible, acceptable and of quality
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CERD	Convention on the Elimination of all forms of Racial Discrimination
CRC	Convention on the Rights of the Child
DRIP	Declaration on the Rights of Indigenous Peoples
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
CRPD	Convention on the Rights of Persons with Disabilities
OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organization

Opening addresses: setting the health rights scene in Aotearoa/New Zealand

Human Rights Commissioner, David Rutherford

In his opening addresses at both workshops, New Zealand's Human Rights Commissioner David Rutherford spoke of New Zealand's leadership in the formation of the United Nations and the Universal Declaration of Human Rights over 60 years ago. However, despite this commitment to human rights, he sees discrimination in New Zealand that amounts to human rights failings, and in particular, in health. He stressed health workers' role as human rights workers.

Mr Rutherford emphasised the legally binding nature of human rights and explained this legal basis shifts the paradigm of care for people who are marginalised and discriminated against from charity to human rights obligations.

To illustrate his concerns about marginalised people he drew on his experiences working with people with intellectual disabilities. Quoting United Nations Secretary-General Ban Ki-moon, he said 200 million people worldwide with intellectual disabilities experience widespread violations of their rights that dehumanise them, denying them respect for their dignity, their individuality, even their right to life itself.

He described states' failings in meeting the rights of people with intellectual disabilities. Although the need is addressed in international conventions and global development priorities, the quality of the data collected on intellectual disability is problematic throughout the world according to the WHO 2011 'World Report on Disability'. This report also stated that health promotion efforts targeting people with intellectual disability can have a substantial impact on improving lifestyle behaviours, increasing quality of life and reducing medical costs.

New Zealand has failed to meet right to health obligations for people with intellectual disability. In 2003 the New Zealand National Health Committee Report referred to the systemic neglect of the health needs of adults with intellectual disability. The report urged the Minister of Health and Minister for Disability Issues to ensure that primary health care providers are aware of the health needs of adults with an intellectual disability. It called for clearly developed policies for access to health care; comprehensive health assessment tools for adults with an intellectual disability; appropriate staff education including peer review processes; health promotion material directed towards and accessible to this population; and prescribing practices that are consistent with best practice guidelines. Mr Rutherford stated these actions have not occurred.

Referring to Ministry of Health research in 2011 that shows greater morbidity and mortality in people with intellectual disability, he said there is something very wrong with how we are developing policy and practice in New Zealand. He argued there is systemic neglect of the health needs of this group of the most vulnerable New Zealanders and this is unacceptable because pragmatic solutions are known but ignored.

Mr Rutherford referenced Professor Paul Hunt: "History teaches us that when people are invisible and stigmatised and demonised, widespread human rights abuses follow" (Hunt 2008).

Children's Commissioner, Russell Wills

Dr Russell Wills, an opening speaker at the Wellington Workshop, said the real value of the United Nations Convention on the Rights of the Child (CRC) is that it describes the world as it should be. But, he said, that is not the way many children in New Zealand experience the world. He spoke of poverty in New Zealand, referring to the gradients that graphically illustrate the association between poverty and health and other social outcomes. He also referred to Wilkinson and Pickett's research published in *The Spirit Level* (2009), which showed that the more unequal a society is, the greater the health and social problems are. New Zealand ranks fourth worst in the OECD countries on these measures.

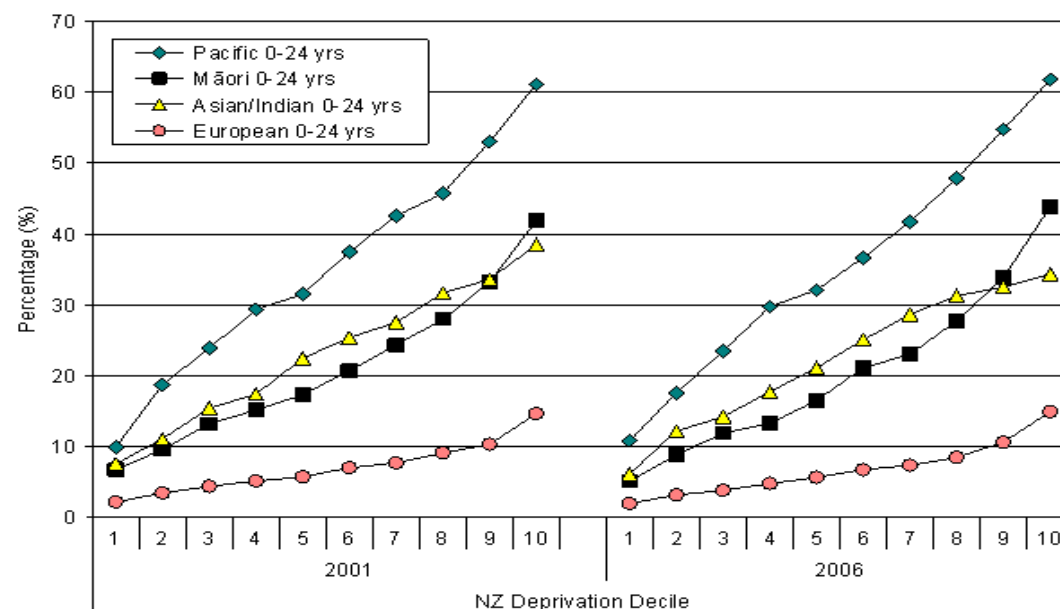
Dr Wills was the first of several speakers to draw attention to the social epidemiology of child health in New Zealand. By viewing the health of children from deprived backgrounds through a rights lens, it is difficult to draw any conclusion other than failings of rights duties, values and service delivery in New Zealand.

He argued that as a society we make choices about how public monies are raised and distributed. He illustrated that there is more equality of wealth amongst the elderly than amongst children. For example, 15 per cent of children live in households with income less than 50 per cent of the median income, compared with less than 2 per cent of the elderly. He said, "The elderly are more equal in New Zealand than children. This is a choice we make".

There is ethnic disparity within each income decile (Figure 1) in New Zealand. These alarming statistics, Dr Wills said, contribute to health outcomes such as Pacific children having a nine times higher rate of admission to hospital for bronchial disorders than Pakeha children. Māori and Pacific infant mortality is twice the Pakeha rate. Similar patterns of health disparity exist in teenage birth rates and attainment of university entrance. Māori conception rate has doubled in the past five years, which he said, raises the question as to whether there is equal access to contraception.

He referred to the usefulness of the 54 Articles in CRC in monitoring how well children are being served, and identified those in Box 1 as of particular relevance to New Zealand. CRC is useful because it not only describes how the world should be for children, but Dr Wills said it also gives a set of values and principles useful for designing, delivering and evaluating services.

Figure 1. Proportion of children and young people 0–24 years living in crowded households by ethnicity and NZ Deprivation Index Decile



Source: Census 2001 and 2006, Statistics New Zealand.

Dr Wills used his own advocacy experience in the Hawke's Bay to argue that even in a fiscally constrained environment, steps can be taken to end discrimination and to achieve equitable outcomes.

Box 1. Key articles from Convention on the Rights of the Child

- Protect children from discrimination
- Make children's interests paramount
- Ensure children's rights to be heard
- Ensure to the maximum extent the survival and development of the child
- Protect children from all forms of violence, injury and abuse
- Ensure appropriate prenatal and postnatal care for mothers
- Ensure children's rights to rest, leisure and play
- Ensure disabled children's active participation in their community
- Develop primary and preventive health care, guidance for parents and family planning education and services
- Services at standards agreed by experts

Keynote address: Paul Hunt

Paul Hunt is Professor of Law at the University of Essex, UK, and was the first UN Special Rapporteur on the Right to the Highest Attainable Standard of Health.

Professor Hunt told how he decided to focus his professional work in human rights on economic, social and cultural rights. His human rights career began with civil and political rights, and this work took him to the Gambia in West Africa where he lived for some time. While living there it became clear that civil and political rights were important, of course, but of equal importance were economic, social and cultural rights, including the right to health, shelter, food, education. He found that it was impossible to neglect these rights — they were the burning issues for people in their day-to-day lives. People grappled with such issues as how to educate their children and how to prevent malaria. He ‘jumped ship’ and since then he has worked in economic, social and cultural rights. He was careful not to diminish the importance of civil and political rights; in fact, he made it clear that they are vital to economic, social and cultural rights.

He argued there is now a growing global movement of health and human rights, as evidenced by the increasing number of civil society organisations working on these issues, as well as the growing number of governments taking health and human rights seriously. There are also thousands of cases of economic, social and cultural rights violations, including concerning the right to health, being brought to trial throughout the world.

“In the past 10 years, a global health and human rights movement has gained momentum, but it doesn’t provide magic solutions. It provides a practical modest tool that shapes effective projects. We want to collaboratively apply the tool to health issues.”

Professor Hunt clarified that the right to health relates far more broadly than just to medical care. He quoted: “As well as access to medical care, the right to health encompasses the social, cultural, economic, political, and other conditions that make people need medical care in the first place, as well as other determinants of health such as access to water, sanitation, nutrition, housing, and education. This wider perspective underscores the very extensive common ground between public health and the right to the highest attainable standard of health” (Hunt, Backman et al. 2009, p338).

This right is far more than a rhetorical device, because it is grounded in international human rights law. “Crucially, the key elements of the right-to-health analytical framework are not merely to be followed because they accord with sound management, ethics, social justice, or humanitarianism. States are required to conform to the key features as a matter of binding law. Moreover, they are to be held to account for the discharge of their right-to-health responsibilities arising from these legal obligations” (Hunt, Backman et al. 2009, p340)

However, Professor Hunt does not pretend that the right to health is simple or easy to apply to complex public health issues: “It is a huge human right and really complicated. A health and human rights approach is still in formation; it is crystallising fast but it doesn’t have neat answers to complex policy and operational issues. There are no neat answers to many such issues. The right to health has a contribution to make without offering facile trite solutions to complex questions. A health and human rights approach raises tricky conceptual and operational issues.”

He spoke of WHO's work in trying to mainstream health and human rights. He noted that health workers, quite rightly, want evidence: "Legal arguments don't wash with health workers. Health workers want to see how a rights-based approach is going to save lives and prevent suffering. For that, we need better evidence. This is new terrain and there is huge scope for new thinking and new practice. These can't be tackled without interdisciplinary collaboration".

There has been a historic neglect of economic, social and cultural rights, and they do not have the same currency as civil and political rights. There is now urgency around making up for that historic neglect, and he outlined some of the ways in which this is taking place.

Whereas lawyers look to vindicate human rights through the courts, Professor Hunt also advocates a 'policy approach'. This approach requires indicators and benchmarks, impact assessments, national human rights institutions, and much more. The right to health must be translated into policy and used by health workers. This is one of the ways in which health workers can be human rights workers.

Over the past five years it has become clearer that there is common ground between health rights and public health. The right to health "depends upon public health measures, such as immunization programmes, the provision of adequate sanitation systems and clean drinking water, health promotion (e.g., regarding domestic violence, healthy eating, and taking exercise), road safety campaigns, nutrition programmes, the promotion of indoor stoves that reduce respiratory diseases, and so on. Just as public health programmes are essential to the realization of the right to health, so too can human rights help to reinforce existing, good health programmes and identify new, equitable, health policies. Public health workers and human rights advocates similarly wish to establish effective, integrated, responsive health systems that are accessible to all. Both stress the importance not only of access to healthcare, but also to water, sanitation, health information, and education. Both understand that good health is not the sole responsibility of the ministry of health, but belongs to a wide range of public and private actors. Both prioritize the struggle against discrimination and disadvantage, and both stress cultural respect. At root, those working in health and human rights are both animated by a similar concern: the well-being of individuals and populations"(Hunt, Backman et al. 2009p34).

"The work of the past few years has started unpacking the 'right to health' bumper sticker," claims Professor Hunt. This has made it easier to apply health rights to health-related policies and programmes. An analytical framework has been developed through the work of the UN Committee on Economic, Social and Cultural Rights, and others. This framework has 10 key elements and has general application to all aspects of the right to health, including the underlying determinants of health (Box 2.). The framework draws extensively on the UN General Comment 14, which gave substantive meaning to the right to health. It also specified that health care and the underlying determinants of health must be available, accessible, and acceptable to all people and of quality. This is referred to as the AAAQ framework, used by people adopting rights-based approaches to health policies, programmes, research and in law.

The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities and accessible to all. "At the heart of this understanding of the right to health is a package of health services, facilities, and goods, extending to health care and the underlying determinants of health, such as access to safe water, adequate sanitation,

and health-related information. This package must be available, accessible, and of good quality. Also it must be sensitive to different cultures.”

In closing, Professor Hunt brought several of his key messages together:

1. The right to health doesn’t demand any radical new departure. It reinforces good public health and development work.
2. It underpins programmes and policies with a legal imperative.
3. The right to health, backed by international human rights law, demands accountability.
4. It brings a useful analytical framework (see Box 2. below); although not new, sadly, history tells us these elements are sometimes forgotten.
5. It can bring greater status, urgency and weight to the imperatives of public health work.
6. There is some hard evidence that a human rights approach has beneficial impact on women’s and children’s health, but this evidence base needs strengthening.

Box 2. Right-to-health analytical framework

The key elements of the right-to-health analytical framework may be briefly summarized as follows:

- 1 Identification of the relevant national and international human rights laws, norms and standards is required: These laws and standards include the ICESCR; CRC; CEDAW; ICERD; DRIP; CRPD as well as regional human rights instruments, and national laws. In New Zealand, this includes Te Tiriti o Waitangi and the NZ Bill of Rights Act 1990.
- 2 States shall recognize that the right to health is subject to resource constraints and progressive realization, requiring the identification of indicators and benchmarks to measure progress over time. The progressive realization of the right to health means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of Article 12, ICESCR. Retrogressive measures, that is, a worsening of health indicators, are not permissible, and if any are deliberately taken, the State has the burden of proven that they were justified.
- 3 States have obligations of immediate effect. Some obligations arising from the right to health are subject to neither resource constraints nor progressive realization, but are of immediate effect, such as the duty to avoid discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, physical and mental disability, health status (including HIV/AIDS), sexual orientation and so forth. “Even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes” (p 338).
- 4 The right to health includes freedoms and entitlements. Examples are: freedom from non-consensual treatment and non-consensual participation in clinical trials) and entitlement to a system of health care and protection. For the most part, freedoms do not have budgetary implications, while entitlements do.
- 5 All health services, goods and facilities shall be available, accessible, acceptable and of good quality (“AAAQ”). This means, amongst other things, that functioning public health and health care facilities and staff have to be available in sufficient quantity, as do underlying determinants of health such as safe and potable drinking water and sanitation; health facilities and services, and health information, have to be physically and economically accessible to everyone without discrimination; all health facilities and services must be respectful of medical ethics and culturally appropriate, that is, acceptable; quality care must be provided, requiring skilled medical personnel and hospital

equipment, unexpired drugs, safe and potable water and adequate sanitation.

- 6 States have duties to respect, protect and fulfill the right to the highest attainable standard of health. Respecting the right to health requires, at the least, refraining from denying or limiting equal access for all persons, to preventive, curative and palliative health services, including access to contraceptives and sexual education. Protecting the right to health requires the State to ensure equal access to health care and services, and that third parties do not constitute a threat to AAAQ of health services; the obligation to fulfill requires the adoption of a national health policy and plan to realize the right to health. Fulfilling the right to health means States must ensure (amongst other things) provision of health care and underlying determinants including nutritiously safe food, potable water, basic sanitation, and adequate housing and living conditions.
- 7 Because of their crucial importance, the analytical framework demands that special attention is given to issues of non-discrimination, equality and vulnerability. The ICESCR proscribes any discrimination in access to health care and underlying determinants of health on any grounds, The UN Committee on ESCR stresses that many measures designed to eliminate health-related discrimination can be pursued with minimum resource implications, and even when there are severe resource constraints, the vulnerable members of society must be protected by the adoption of low-cost targeted programmes. To eliminate discrimination against women, national strategies for women's right to health are called for; as is special attention to the right to health for indigenous peoples, children, older persons and persons with disabilities.
- 8 The right to health requires that there is an opportunity for the active and informed participation of individuals and communities in decision making that bears upon their health. Participation is a key human rights concept that provides for community involvement in the formulation and implementation of government policy, and with respect to health, to be involved in all health-related decision making at the community, national and international levels.
- 9 Developing countries have a responsibility to seek international assistance and cooperation, while developed States have some responsibilities towards the realization of the right to health in developing countries. General Comment 14 draws attention to the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, that is politically, socially and economically unacceptable and is of common concern to all countries. States must respect the right to health in other countries and prevent third parties from violating the right in other countries. Further, they should also ensure that international organizations take due account of the right to health.
- 10 The right to health requires that there are effective, transparent and accessible monitoring and accountability mechanisms available at the national and international levels. These mechanisms provide rights-holders (individuals and groups) with an opportunity to understand how duty-bearers (primarily States, ministers and officials) have discharged their obligations, and to explain their conduct. Accountability can encourage effective use of limited resources. "Transparent, effective and accessible accountability mechanisms are among the most crucial characteristics of the right to the highest attainable standard of health" (United Nations 2000, para 18).

New Zealand case studies viewed through the right-to-health analytical framework

Health of indigenous children

Ms Riripeti Haretuku was the Programme Director of the National Māori SIDS programme, is a member of Action for Children and Youth Aotearoa (ACYA), the National Health Committee and Public Health Advisory Committee, and is the CEO of Mauri Ora Associates.

The theme and message of Ms Haretuku's presentation was New Zealand's urgent imperative to address the poor state of indigenous children's health. She traced the origins of poor health outcomes of indigenous children to historic and persistent acts of colonisation.

Today Māori children are more likely to:

- die as a result of injuries, poisonings, road traffic injuries, SIDS, respiratory conditions, and infectious diseases — all potentially preventable health conditions;
- be admitted to hospital in the first five years of life for respiratory conditions; injuries and poisoning, and nervous system diseases;
- be truant, leave school early;
- be over-represented in the disability statistics;
- be born into social and economic circumstances that exacerbate illness;
- attempt suicide;
- appear in juvenile court in their youth.

Te Tiriti o Waitangi sets out some specific guidelines for racial harmony and relations in New Zealand between Māori and the Crown. These specific guidelines are a constant tension between Māori and the Crown primarily because there are significant political, social and economic resource implications when apportioning resource and responsibility to addressing the high mortality and morbidity rates of Māori children. Attempts by successive New Zealand governments to greatly reduce these disparities is minimal and promises seem to be nothing more than rhetoric.

The underlying causes of these poor health indicators include minimal educational attainment that correlates with high unemployment rates, increased stress and physical and substance abuse. Ms Haretuku said that the health system is the bottleneck for multiple issues that are failing these children, and this has caused huge breakdowns in family systems. These breakdowns are reflected in violence, crime, murder, child abuse, maltreatment and youth suicide.

Ms Haretuku believes accountability mechanisms are necessary to support New Zealand governments' ability to apply the intent of Te Tiriti. Furthermore, she is interested to see how human rights law will provide answers for non-compliance with Treaty intentions and CRC obligations.

Box 3. UN covenants pertaining to indigenous children's health rights

CRC: Article 30 is of special importance to indigenous children because it recognises their rights to be indigenous.

- In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

UN Declaration on the Rights of Indigenous Peoples: Article 24 expresses the rights of indigenous people to the highest attainable standard of physical and mental health.

Child poverty in New Zealand

Dr Susan St John, Associate Professor/Co-Director, Retirement Policy and Research Centre, University of Auckland

Dr Susan St John said child poverty in New Zealand is experienced through damp, cold housing, unsafe environments, poor access to health care, and households with low income, high housing costs and debt. Although 20 years of reports have shown a clear correlation between actions such as benefit cuts, child poverty and rising “third world diseases”, Dr St John questions why there has been so little action to address this increasing problem. Even the Ministry of Social Development admits there is no doubt that “...19% of children experience serious hardship and unacceptably severe restrictions on their living conditions for citizens in a developed nation like New Zealand” (MSD 2009). This represents at least 200,000 children living in poverty.

As a result of increasing hardship for poorest families in New Zealand, the ‘charity model’ has developed with support for children in poverty being provided by the non-state sector rather than from the State. For example, food bank use has increased dramatically between 1996 and 2011. This shift away from State responsibility is consistent with the political discourse of child poverty that frames the social issue as one of individual responsibility, and one in which employment is seen as the way out of poverty.

Dr St John says the issue of child poverty has not benefited from rational debate, but rather, has suffered from ideological posturing. Rational debate, even if limited to economic arguments, would have shown that the costs of child poverty are very high. Similarly, the economic benefits to the country of investment in children as our future workforce are great. However, advocacy for these approaches has not gained any traction. Dr St John attributes this to an ingrained prejudice and fear of the stereotype of people on welfare benefits, who are presented as “a group that breed for money” and the solution to child poverty in New Zealand has been seen as simply to ‘get a job’.

Single parents however have many barriers to finding employment, including child-unfriendly work hours, or local environments — including access and cost of child care. But paid work was seen as such an important solution to child poverty, that working parents are incentivised by receiving a significant amount of financial support (at least \$60 per week) through the In-Work Tax Credit (IWTC). Therefore children of beneficiaries are denied a

significant amount of financial support. The Child Poverty Action Group (CPAG) maintains that a large majority of beneficiary parents cannot obtain work, or are not able to meet the incentivised work requirements due to a lack of jobs, ill health, disability or child care responsibilities. “The Government’s own estimates when introducing the IWTC were that only a tiny number of beneficiaries (around 2 percent) would be able to leave the benefit and obtain it. Yet the IWTC excluded the entire group of beneficiary parents and their children from additional family income which was and is desperately needed to pay for basic living costs such as food, rent and power.”

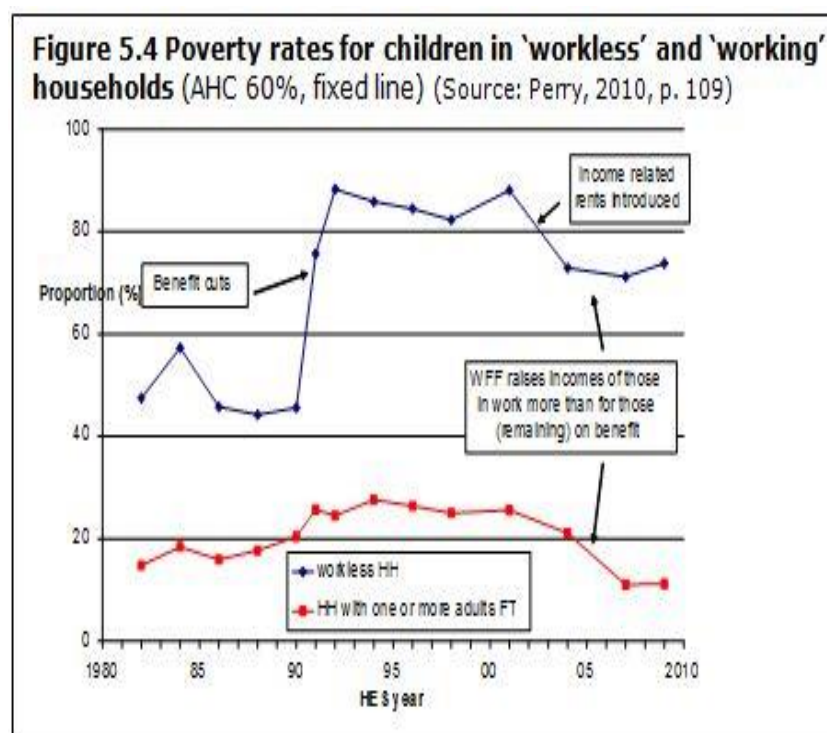
CPAG believes there were better ways to create an income gap that would leave plenty of Government funds for distribution to all parents on low to middle incomes. Instead the Government paid money to those higher up the income scale, keeping children in poverty.

The Working For Families scheme was successful in reducing overall child poverty in New Zealand, but “it had little if any impact on the poverty rates for children in workless households”, according to the Ministry for Social Development in 2010.

The Human Rights Tribunal in 2008 found: “We are satisfied that the WFF package as a whole, and the eligibility rules for the IWTC in particular, treats families in receipt of an income-tested benefit less favourably than it does families in work, and that as a result families that were and are dependent on the receipt of an income-tested benefit were and are disadvantaged in a real and substantive way” (Human Rights Review Tribunal of New Zealand 2008)

Dr St John said a human rights-based approach would call for a new focus: it would start with asking what a woman with young children would need to thrive; it would admit that she is working; it would wrap her around with support and would stop tying social provision to narrow concepts of paid work. Importantly, it would not victimise and exclude some poor children from poverty alleviation measures, but it would place the child at the centre of a paradigm to determine how best that child could flourish.

Figure 2. Poverty rates for children in 'workless' and 'working' households



Source: Perry, 2010, page 109.

Childhood obesity in New Zealand

Associate Professor Louise Signal, Director, Health Promotion and Policy Research Unit, University of Otago, Wellington
and

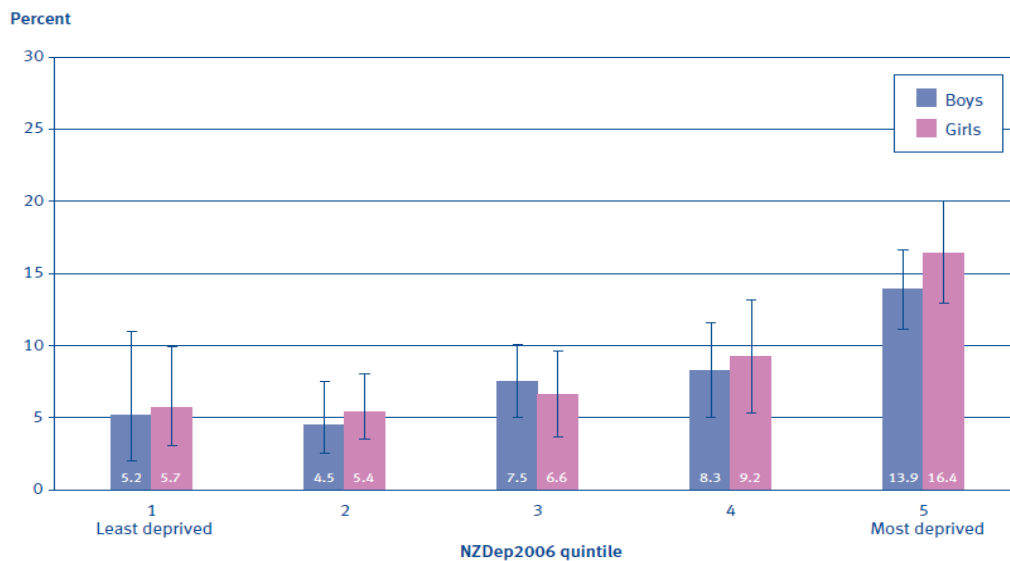
Dr Gabrielle Jenkin, Research Fellow, Health Promotion and Policy Research Unit, University of Otago, Wellington

Drs Signal and Jenkin presented data showing that NZ children have high rates of obesity and rank fifth in obesity out of 33 OECD countries behind Greece, the US, Italy and Mexico (Hunt, Backman et al. 2009, p339). The 2006/07 New Zealand Health Survey (International Association for the Study of Obesity 2011) found that:

- one in twelve children (aged 2 to 14 years) were obese (8.3%);
- one in five children were overweight (20.9%).

Pacific boys and girls were at least 2.5 times more likely to be obese than boys and girls in the total population. Māori boys and girls were 1.5 times more likely to be obese than boys and girls in the total population.

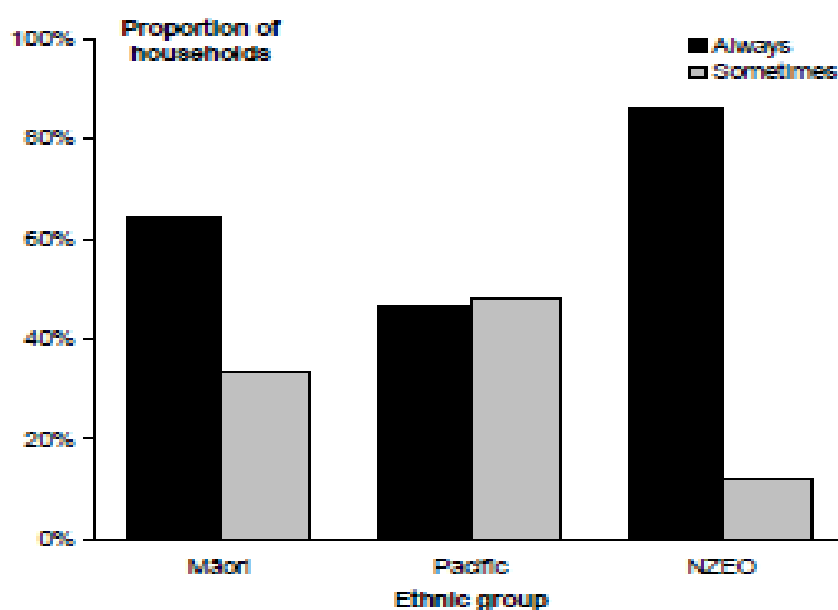
Figure 3. Obesity for children, by NZ Dep 2006 quintile and gender (age-standardised prevalence)



Source: Ministry of Health. (2008.) *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

They referred to the 2002 National Children’s Nutrition Survey (Ministry of Health 2008) to show, once again, a very clear gradient: the more deprived households are, and the less “food secure” they are, the less they can afford to eat properly. Further data from New Zealand shows that Pacific and Māori households are less likely to be always able to eat “properly”; i.e., healthy food, compared to European and other New Zealanders. It can be concluded that the quality and quantity of food available to households varies significantly in New Zealand depending on the level of deprivation people suffer and in which ethnic group they belong to.

Figure 4. Can *always* and *sometimes* afford to eat properly



Source: Ministry of Health. (2003.) NZ Food NZ Children: Key results of the 2002 national children's nutrition survey. Wellington: Ministry of Health.

Against this backdrop, Dr Jenkin and colleagues conducted a study of foods advertised during children's television viewing times (Ministry of Health 2003). Two-thirds of food advertisements were for unhealthy foods. Each week, children who watch two hours of television each day will see around 54 unhealthy food advertisements. Similarly, food advertised in the neighbourhoods of schools was predominantly for unhealthy food (70.2%) and food sold near schools was also mainly unhealthy (Jenkin, Wilson et al. 2009).

Analysis of the popular discourse around obesity showed the focus was on the individual — that the individual, not society and food availability and affordability — was to blame in obesity (Maher, Wilson et al. 2005). However, society makes unhealthy eating the easy choice for people, especially resource- and time-poor people.

The Health Select Committee on Obesity and Type II diabetes recommended key public health policy changes to promote healthier eating. These covered the areas of the National Healthy Eating Healthy Action Strategy (its overall direction and focus), the regulation of the food industry, the regulation of the marketing industry and nutrition policy in school environments. An analysis of the government response found, in most cases, that the government aligned with the interests of industry rather than public health. In particular, the government rejected the Committee's recommendation for simple front-of-pack food labelling, 'traffic light' labelling, that would enable consumers to quickly identify the nutritional value of the food. It also rejected the recommendation to restrict television advertising of unhealthy food to children (Jenkin, Signal et al. 2011a).

Drs Signal and Jenkin concluded that children's right to health was not being protected in relation to obesity in New Zealand. Not only does New Zealand have alarmingly high rates of childhood obesity, but this burden is disproportionately borne by Māori and Pacific children and children living in low-income households. They presented evidence of the causes of obesity, which include food insecurity and the advertising and availability of unhealthy food to children. They highlighted the individual 'victim blaming' focus of much discourse on solutions to the problem and the failure of government to protect the rights of children in their policy response to a Health Select Committee on Obesity.

Rheumatic fever in New Zealand

Dr Richard Jaine, Department of Public Health, University of Otago, Wellington, New Zealand

Acute rheumatic fever (ARF) and its sequelae chronic rheumatic heart disease (CRHD), remain significant causes of morbidity and mortality in New Zealand, almost exclusively among Māori and Pacific peoples.

Rates have not declined since the 1980s, with about 145 deaths per year from this preventable communicable disease. Dr Richard Jaine compared this to death rates from drowning (about 130 per year), or cervical cancer (60 per year) — both of which have been subject to large public health campaigns, unlike rheumatic fever. Yet the costs of rheumatic fever are significant in terms of the reduction in quality of life, reduced productivity, financial loss and intangible emotional impacts. It has been estimated that in 2002, almost six million disability-adjusted life years were lost to rheumatic fever or its complications (Jenkin, Signal et al. 2011b).

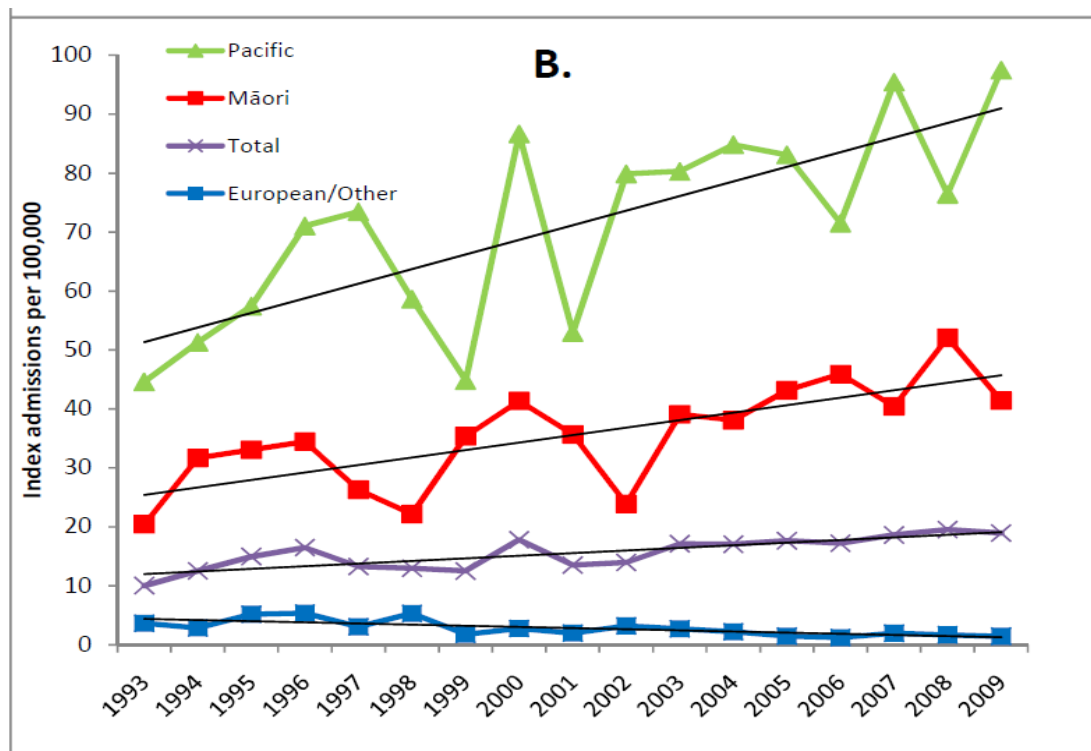
In developed countries the rates of rheumatic fever have decreased markedly since the 1950s to less than one per 100,000 people. This is thought to be due to improved living standards, less crowded homes, and widespread use of antibiotics. However, in developing countries, including the Pacific Islands, the rate has been increasing since the 1940s, and is now between 10 and 100 cases per 100,000 people. New Zealand is not like other developed countries, with morbidity rates still at 3.5 per 100,000, and around 15 per 100,000 in 5 to 14 year olds. Although this rate has fallen from 70 per 100,000 in 1970, it remains consistently higher than that in developed countries. This age group accounts for 70 per cent of all cases in New Zealand.

Historically and currently, Māori rates of morbidity and mortality are 10 to 20 times higher than for non-Māori, and Pacific peoples rates are 10 to 75 times higher than non-Māori or Pacific. Overall, between 80 and 97 per cent of all cases of rheumatic fever in New Zealand occur in Māori or Pacific people. In 2009, 97 per cent of acute rheumatic fever cases in 5 to 14 year olds were in Māori or Pacific ethnicities. Māori and Pacific children make up only 29 per cent of the 5 to 14 year old population in New Zealand, and they are only 5 per cent of the total New Zealand population. Therefore, the fact they make up 97 per cent of the cases of rheumatic fever is very disturbing. Furthermore, ethnicity itself is not a cause of rheumatic fever; rather, low socioeconomic status is associated with high rates of the disease in both developed and developing countries. Household crowding is associated with increases in infectious diseases, but this is confounded by income, education and occupation (Carapetis, Steer et al. 2005).

Primary and secondary prevention is effective against this disease: most individual cases can be prevented by the appropriate treatment of sore throats in high-risk populations. Intramuscular penicillin will then prevent recurrences, and therefore rheumatic heart disease.

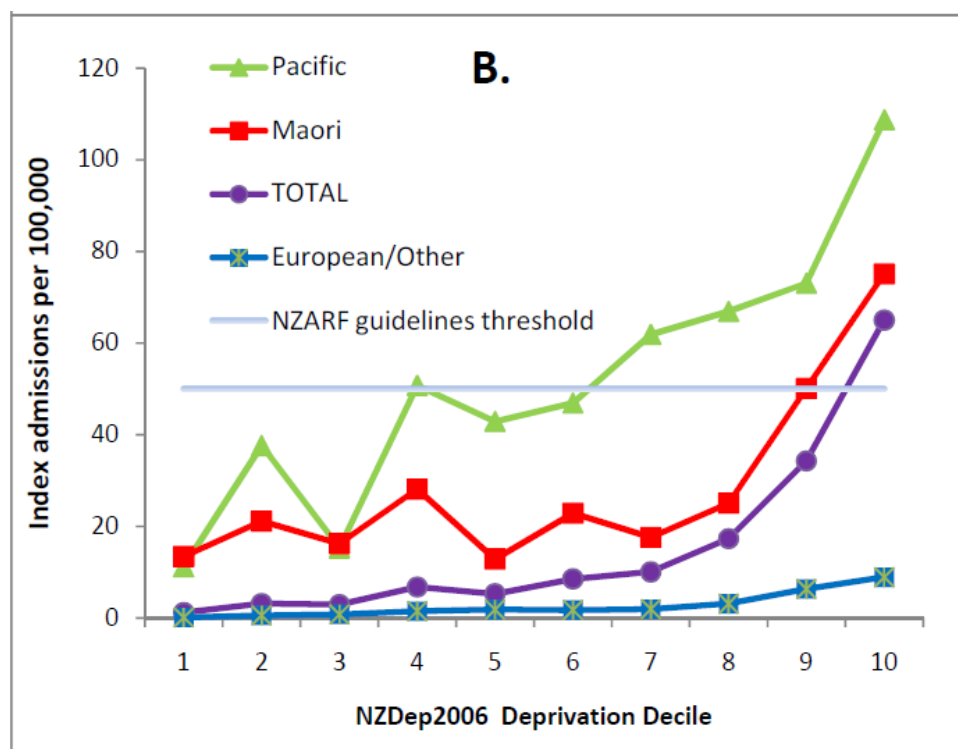
Primary prevention has been inadequate in New Zealand. Ethnic disparities for ARF are widening. Guidelines have been recommended in New Zealand for targeted school screening programmes that now need to be implemented.

Figure 5. Annual incidence rates of ARF for children 5–14 years by ethnicity, 1993–2007



Source: (Baker, McNicholas et al. 2000; Baker, Das et al. 2008; Jaine, Baker et al. 2011).

Figure 6. ARF incidence rates for children 5–14 years by socioeconomic deprivation and ethnicity, 2000–2009



Source: (Milne, Lennon et al. 2012).

Rights-based analysis of child health in New Zealand

Professor Hunt examined the issues raised in various presentations on indigenous children by drawing on General Comment 14, starting with Section 27, “Indigenous peoples”, which states,

...indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate...States should provide resources for indigenous peoples to design, deliver and control such services. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension.

Professor Hunt also made reference to the Declaration on the Rights of Indigenous People, which was “profoundly shaped by indigenous peoples around the world”.

The over-representation of Māori children in poor social and health indicators is consistent with the profound disparities between the health of indigenous people and non-indigenous populations in many countries, and on which Professor Hunt reported when he was Special Rapporteur (A/59/422, s55) (Milne, Lennon et al. 2012).

In referring to the concerns of perceived failings of Te Tiriti promises, Professor Hunt drew on one of his Special Rapporteur UN Reports that called for urgent and concerted efforts, at local, national and international levels, towards reversing these trends. “According to international human rights law, indigenous people have the right to specific measures to improve their access to health services and care as well as the underlying determinants of health” (A/59/422, s58) (United Nations 2004).

Accountability and remedies

The lack of progress — or worse, regression of some health indicators in Māori children — raised the subject of human rights accountability. Professor Hunt explained that accountability is more than measuring. “Collecting disaggregated data is important but it isn’t accountability. Once we have the data we then need someone independent to say ‘things are getting worse’. Therefore, human rights accountability depends upon independent monitors and with indigenous people’s health, the right to health must include the right to a narrow gap.”

Referencing Dr Helen Potts’ work on accountability (United Nations 2004), he said that human rights accountability was defined as the “process which requires government to show, explain and justify how it has discharged its obligations regarding the right to the highest attainable standard of health”. A rights-based approach to accountability ensures that the processes of accountability are transparent and participatory. “The accountability process requires the incorporation of monitoring into all aspects of policy development and implementation. This monitoring is conducted on a continuous basis by government. It can also be conducted by civil society, either collaboratively with government or independently...an effective accountability process is comprised of the following essential elements: monitoring, mechanisms, remedies, and participation” (Potts 2008).

Professor Hunt called for stronger accountability mechanisms in New Zealand that are independent from government. Human rights are about empowering individuals and

communities, and identifying remedies for human rights failings. For example, if a country has an unsatisfactory health information system (such as shown below in Dr Teuila Percival's case study in the Pacific), then it must put in place a good health information system. This is one of the remedies that must be made, and it is a breach of international human rights law if it isn't made.

Box 4. Using the analytical framework to examine child health in New Zealand

FRAMEWORK	ISSUES ILLUSTRATED
<p>1 Identification of the relevant national and international human rights laws, norms and standards;</p>	<p>Te Tiriti o Waitangi, 1840</p> <p>NZ has ratified these Human Rights conventions and declarations:</p> <p>Following the adoption of the Universal Declaration on Human Rights in 1948, New Zealand ratified:</p> <ul style="list-style-type: none"> • United Nations Convention relating to the Status of Refugees in 1960 — NZ acceded on 30 June 1960 • International Convention on the Elimination of All Forms of Racial Discrimination — NZ signed 25 October 1966 and it was ratified 22 November 1972 • International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights — both signed 12 November 1968 and ratified 28 December 1978 • Convention on the Elimination of All Forms of Discrimination Against Women — signed 17 July 1980 and ratified 10 January 1985 • Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment — signed 14 January 1986 and ratified 10 December 1989 • United Nations Convention on the Rights of the Child — signed 1 October 1990 and ratified 6 April 1993. • Convention of the Rights of Persons with Disabilities — signed 30 March, 2007; ratified 26 September, 2008 • Declaration on the Rights of Indigenous People — signed in 2010
<p>2 Recognition that the right to health is subject to resource constraints and progressive realisation, requiring the identification of indicators and benchmarks to measure progress over time;</p>	<p>Indicators or other data have not been identified to measure rights of children with intellectual disability</p> <p>Rheumatic fever indicators are not improving in Māori and Pacific children</p> <p>Many indicators of poor health from overcrowded and inadequate housing have worsened over the past 20 years, as shown by health researchers cited by CPAG</p>

FRAMEWORK	ISSUES ILLUSTRATED
	Childhood obesity worsening in New Zealand, and promotion of unhealthy food choices supported by government
3 Obligations of immediate effect: some obligations arising from the right to health are subject to neither resource constraints nor progressive realisation, but are of immediate effect, such as the duty to avoid discrimination;	Poor health outcomes in Māori and Pacific children, and in those who are living in families who are not in paid employment are suggestive of discrimination
4 Recognition that the right to health includes freedoms (e.g. freedom from non-consensual treatment and non-consensual participation in clinical trials) and entitlements (e.g. to a system of health care and protection). For the most part, freedoms do not have budgetary implications, while entitlements do;	The entitlement of Māori and Pacific children and adults to public health programmes to protect them from rheumatic fever and other avoidable morbidity appears to have not been met
5 All health services, goods and facilities shall be available, accessible, acceptable and of good quality;	<p>Preventive health services have not been made sufficiently available or accessible to some people, especially as shown in the rheumatic fever case study where Māori and Pacific children are not receiving the preventive care necessary to avoid ARF and its sequelae;</p> <p>Māori child health indicators are worse than for non-Māori in all infectious diseases and respiratory conditions.</p>
6 States have duties to respect, protect and fulfill the right to the highest attainable standard of health;	The Child Poverty Action Group has shown that children's rights have not been protected by the Working For Families payment scheme; there has been failure to fulfill health rights in all the case study examples, including the rights to the underlying determinants of health; Māori and Pacific children, and children living in poverty, have not had their rights to health respected through introduction of legislation that discriminates against their families' lack of paid employment
7 Because of their crucial importance, the analytical framework demands that special attention is given to issues of non-discrimination, equality and vulnerability;	High prevalence of diseases such as rheumatic fever in Māori and Pacific children demonstrates there is discrimination, inequality and vulnerability. The Working for Families scheme has been shown to discriminate against children whose parents are not working — thus special attention is not being given to issues of non-discrimination,

FRAMEWORK	ISSUES ILLUSTRATED
	<p>equality and vulnerability</p> <p>Active promotion of unhealthy food choices affects Māori and Pacific children disproportionately</p>
<p>8 The right to health requires that there is an opportunity for the active and informed participation of individuals and communities in decision making that bears upon their health;</p>	<p>Whānau Ora could be a good example of community participation in health decisions</p>
<p>9 Developing countries have a responsibility to seek international assistance and cooperation, while developed States have some responsibilities towards the realisation of the right to health in developing countries;</p>	<p>The Millennium Development Goal (MDG) commitments can restrict developing countries' capacity to seek international development for health priorities other than those prescribed by the MDGs</p>
<p>10 The right to health requires that there are effective, transparent and accessible monitoring and accountability mechanisms available at the national and international levels.</p>	<p>Such mechanisms are not adequate to measure human rights accountability presently in the Pacific, or in New Zealand — the CPAG case may demonstrate a disregard of human rights entitlements</p>

International human rights obligations

Millennium Development Goals: Are they improving the health of children in the Pacific Islands?

Dr Teuila Percival, Pacific Health Section, School of Population Health, University of Auckland

Millennium Development Goal (MDG) 4, to reduce child mortality, is the goal most directly linked to children's health. Its achievement has become the leading child health indicator in the Pacific on which the success of policy, services and resourcing is measured. Dr Teuila Percival said some countries in the Pacific would seem to have achieved MDG 4 already. However, she expressed concern that the risk of having done so is that once achieved, there is the potential for governments and external donors to then divert or disinvest in broader child health policies and programmes.

The MDG emphasis on achieving mortality reduction in children aged five and under distracts from the need for more sensitive indicators of disease burden, determinants of health and service delivery, said Dr Percival.

Samoa and Tonga data shows reduced under-5 mortality. However, there is an underlying disease burden that concerns frontline clinicians. But data is not available that would enable them to advocate for greater State and donor investment in children's health policy and services.

To address this health information deficiency, national and regional child health experts developed a set of functional, clinically relevant indicators for nine priority child health conditions. Indicators were based on the reliability, availability and timeliness of current health information available in Samoa and Tonga. Hospital based data was found to be the only routinely captured information. Nine priority child health concerns were identified (Box 5).

Box 5. Consensus priority child health concerns in Samoa and Tonga

1.	Acute respiratory disease (pneumonia and bronchiolitis)
2.	Gastroenteritis
3.	Childhood injury
4.	Severe malnutrition (marasmus and kwashiorkor)
5.	Immunisation rates and vaccine preventable disease
6.	Neonatal morbidity (low birth weight and preterm babies, congenital abnormalities)
7.	Neonatal mortality
8.	Rheumatic fever and rheumatic heart disease
9.	Childhood cancer

The data collected showed concerning health trends, such as increased hospitalisation for marasmus and kwashiorkor. These indicators reveal a different story of child health in these countries from what achieving MDG 4 would suggest. Therefore, accurate and effective data collection, capturing well-selected indicators of child health, will result in more responsive

and appropriate development of policy and services to better meet the needs of children in the Pacific.

Dr Percival discussed the need for governments and donor agencies to commit to effective monitoring and measurement of health. “Every birth and every death should matter enough that at the very least we count it.” She argued that there is a real risk in claiming achievement of MDGs 4 and 5 (improving maternal health), because achievement of these MDGs has become the crucial indicator in the Pacific of success of policy, services and resourcing.

Averaging under-5 mortality in Pacific Island countries is an insensitive measure of children’s health that does not reflect the burden of child suffering and disease. Mortality data in the region is also of variable accuracy and usefulness. The emphasis on this indicator distracts from the need for development of sensitive indicators of disease burden, determinants of health and service delivery, along with country-level health information systems.

Impact of trade agreements on Pacific health

Barry Coates, Executive Director, Oxfam New Zealand

Barry Coates described the complexities of trade policy and health as a “wicked problem”, with added dimensions of difficulty in the Pacific across diverse cultures and with varying levels of government capacity. There is also a lack of data and research that limits the measurement and monitoring of trade impacts.

The need for impact analysis has become even more important since the scope of trade agreements now extends far beyond the usual understanding of ‘trade in things’ to include government regulation in service sectors such as health (and health-related services), intellectual property rights and investment.

Insights into the trade and health links can be gained from international studies that have traced the impact of trade policies through their translation into macro and sectoral levels, and identified systematic impacts on health institutions, incentives and outcomes. In other cases, research has examined observed health outcomes and documented causal links to trade policies. It is important to be able to adopt a sound approach to draw inferences about the impact that trade policies have on health, even if the evidence does not allow a rigorous proof of causality.

Trade in the Pacific is marked by a concerted push from the major external actors (governments of Australia, New Zealand, EU, others), inter-governmental agencies (World Bank, Asian Development Bank) and trade ‘experts’ to promote trade liberalisation. Civil society organisations are usually characterised as being “anti-trade” because they are advising sound assessment and democratic debate with regard to liberalisation proposals.

The Pacific Island Countries (PICs) are simultaneously negotiating free trade agreements with Australia and New Zealand, the EU, each other, China, and for some, entry to the World Trade Organisation. Most countries lack the capacity to prepare sufficiently for the negotiations. There is also a lack of capacity and cross-governmental cooperation that would support undertaking research into the likely impacts of these deals on health (as well as on poverty, environment and other issues).

In the Pacific, liberalisation of trade in goods plays a role in health-related issues such as unregulated imports of unhealthy products (including waste meat and tobacco), the displacement of locally produced foods by imported food (sometimes dumped at cheap prices), the loss of government revenue from tariff liberalisation (in Kiribati, Tonga and Vanuatu, the loss of government revenue from reducing tariffs potentially amounts to more per year than the government's spending on health), and a loss of jobs in local businesses that are displaced by cheaper imports.

A new trade agreement on services (the General Agreement on Trade in Services — GATS) was agreed in 1994 at the conclusion of the Uruguay Round of trade negotiations. There has been pressure on developing countries in the World Trade Organisation to make new commitments, including in sectors such as health care and related services.

The scope of such agreements is very broad (services are often described as “anything you can't drop on your foot”) and it is difficult for developing countries to be able to assess objective assessments on the potential impact of such commitments. In recent years, there has been far greater caution exercised over these commitments, particularly since the rules are complex and they are locked in, so that it is difficult to relax or remove the commitments once made. The disciplines aim to not only prevent preferences being provided to local providers, but also to remove any domestic regulations (discriminatory or not) that are deemed to be “unnecessary barriers to trade”. There is widespread concern that legitimate health policies to support improved health outcomes or to require universal service obligations may be deemed under WTO case law to be “unnecessary”.

Trade rules also cover intellectual property rights since 1994 (Trade Related Intellectual Property Rights — TRIPS). Oxfam and other NGOs have campaigned to ensure that TRIPS does not undermine access to essential medicines at affordable prices, especially in low-income countries. However, the minimal protections that have been gained in the WTO are being eroded in other trade agreements. The United States has pushed for provisions that go beyond TRIPS to be included in the conditions for countries to enter the WTO (such as for Tonga accession in 2005). There is now a concerted push to extend the provisions of TRIPS under new bilateral and regional trade agreements, most notably under the Trans-Pacific Partnership Agreement.

Each of these new trade agreements have common elements and they share a fundamental paradigm — that there should be as few restrictions as necessary to the movement of corporations and their products between and within countries. The definition of what are “necessary” restrictions is most often decided within the dispute settlement mechanism of the WTO, according to its agreements and case law. What appears to be unnecessary to a foreign investor may, in reality, reflect sound public policy aims. But the WTO's rules are enforceable whereas most UN agreements are not, and conflicts between freedoms for corporations and public health aims are all too often resolved in the WTO.

Health outcomes in the Pacific are of deep and urgent concern, particularly non-communicable diseases (NCDs), such as diabetes. A particular issue causing NCDs is the widespread change in diet, away from locally produced foods towards consumption of imported foods, including unhealthy food such as waste meat that has high levels of saturated fat. These dietary changes are related to changes in the patterns of trade and to trade policy. For example, the Samoan government ban on the importation of turkey tails, with a high

content of saturated fat, was dropped as a condition for Samoa to join the World Trade Organisation.

There is growing awareness about the health problems from eating unsafe and unhealthy imported waste meat, but the relatively weak efforts to raise public awareness are unlikely to have a sufficient impact to prevent a generation that suffers debilitating health problems and early mortality. Stronger policy measures are required in the Pacific and in exporting countries to meet the challenge of a 'right to health' for all. These measures should not be undermined by trade agreements.

Trade policy is increasingly influential in setting the framework for public policy on health care. It is crucial that the logic of health rights determines the policies pursued by governments, instead of the logic of corporate rights.

Further comments on trade impacts

Sione Tu'itahi, Executive Director, Health Promotion Forum

Mr Sione Tu'itahi reflected on his own experiences growing up in Tonga, and asked questions for further consideration within a health rights framework. He witnessed the change in diet and lifestyle as Tonga began to import unhealthy foods, especially mutton flaps, in the 1960s from New Zealand.

He argued that the import of mutton flaps and turkey tails stems from the same economic paradigm that allows the poaching of medicinal knowledge and plants, mining resources and storage of nuclear waste. "Our dominant ways of economic development are characterised by exploiting and destroying our limited resources," said Mr Tu'itahi.

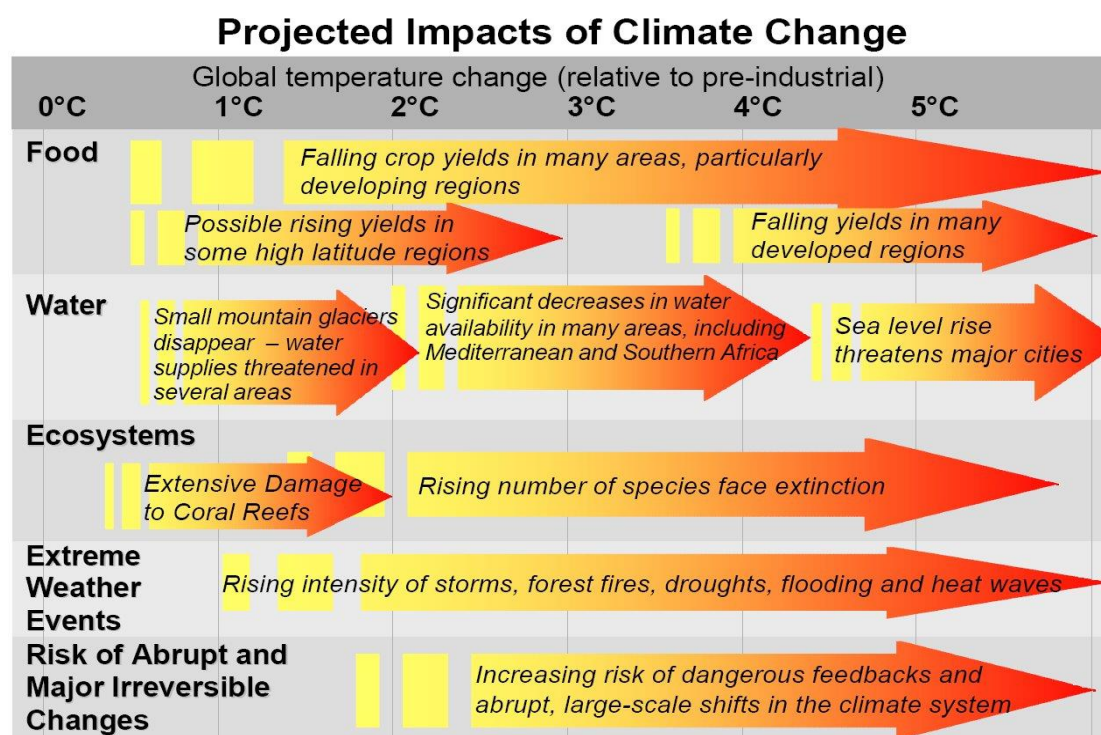
He ended his response by stating that a rights-based approach can promote greater equity and should be used to re-examine the underlying assumptions and values that are implicit in the free market economy. He believes health and human rights is a better fit with the traditional Pacific holistic systems that include the material and spiritual dimensions of wellbeing and prosperity.

Climate change is a public health issue

Dr Rhys Jones, School of Population Health, University of Auckland

Dr Rhys Jones addressed the public health impacts of climate change, and stressed that there is no longer any doubt that climate change is happening due to human activity. Even the most optimistic predictions see the temperature of the earth increasing by 2.3 degrees before the year 2100. The consequences of this are shown in Figure 7.

Figure 7. Projected impacts of climate change



Source: Stern report, 2006. www.sternreview.org.uk

As health and wellbeing are dependent on the stability of social, cultural and economic conditions, and the sustainability of natural ecosystems, Dr Jones said the climate change will have both direct and indirect effects on these.

He demonstrated through two cartograms (Figures 8 and 9 below) to illustrate that the countries least responsible for producing carbon emissions are those suffering the greatest mortality as a consequence of global warming.

Figure 8. Density equalling cartogram. Countries scaled according to cumulative emissions in billion tonnes carbon equivalent in 2002

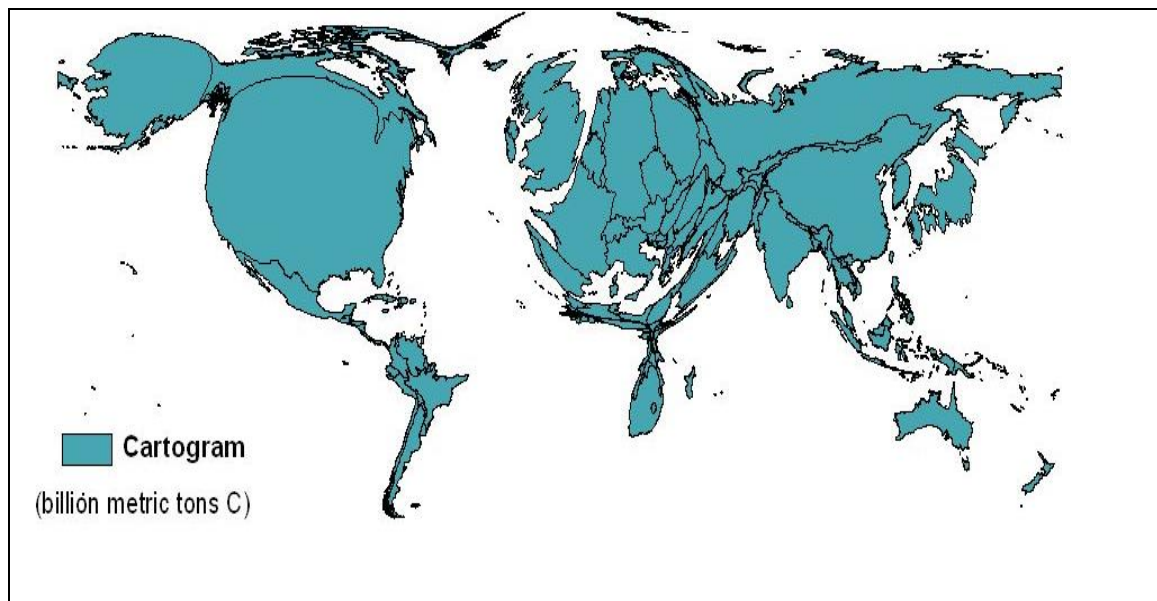
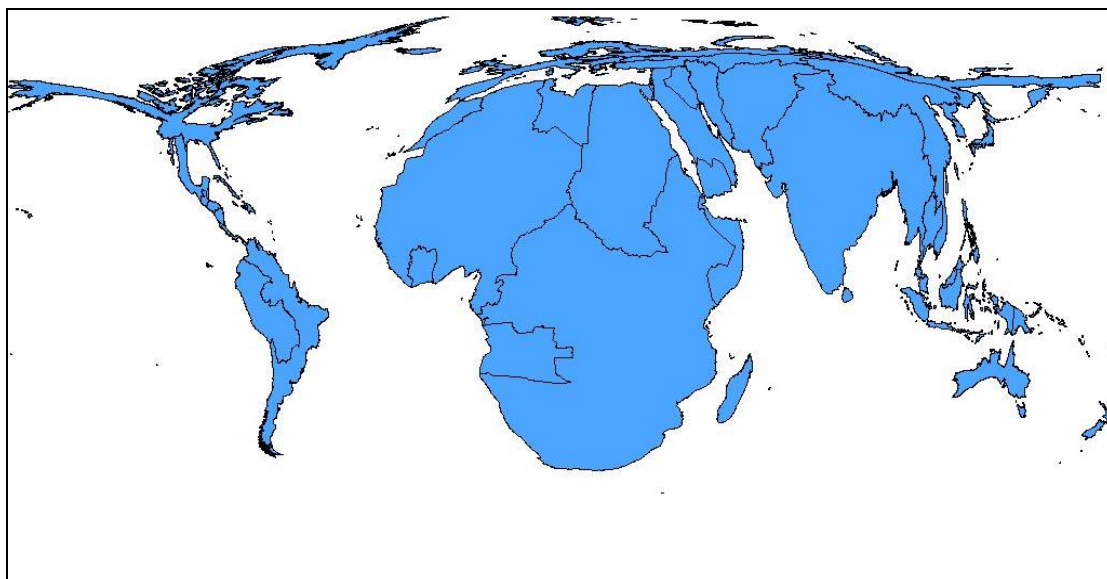


Figure 9. Density equalling cartogram. WHO regions scaled according to estimated mortality (per million people) in the year 2000, attributable to climate change from 1970s to 2000



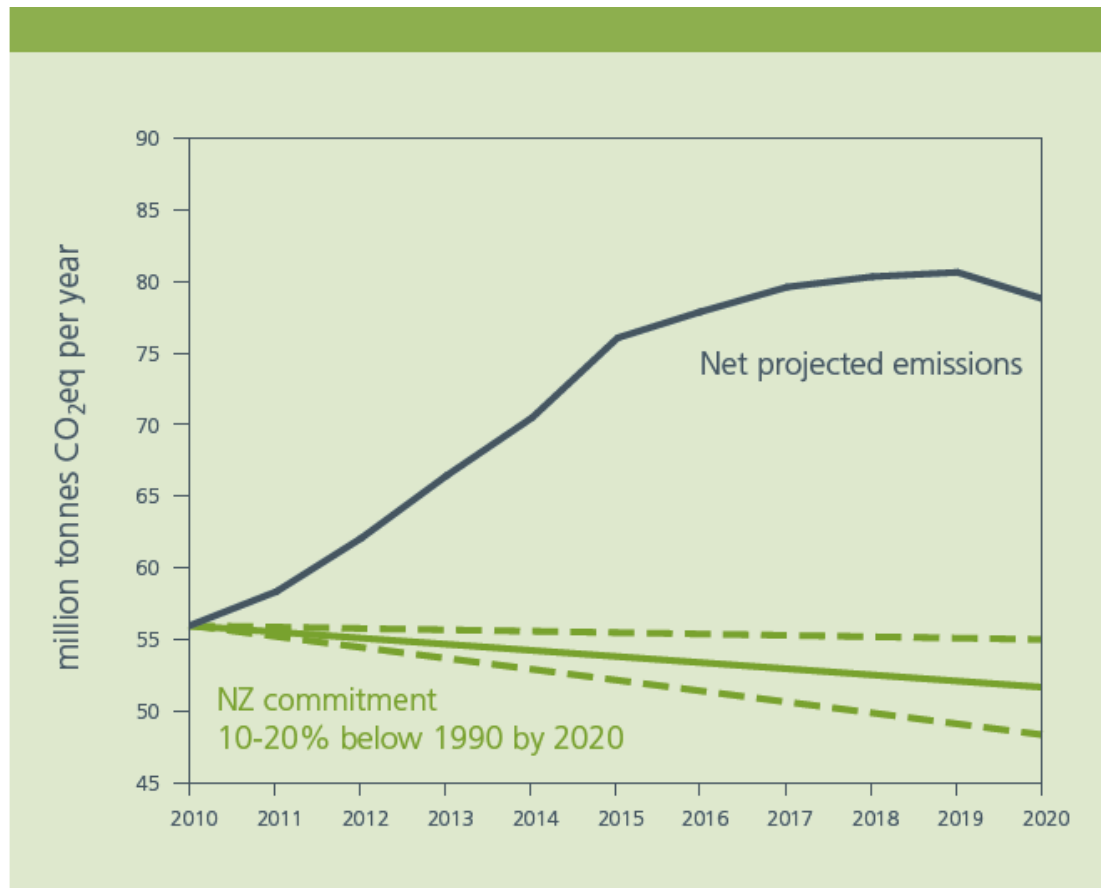
Source: Patz, J. A., et al. (2007). *Climate change and global health: Quantifying a growing ethical crisis*. *EcoHealth*, 4(4), 397–405.

Dr Jones referred to remarks by the White House science director John Holdren that there are three possible responses to climate change: mitigation (cutting emissions), adaptation and suffering. “We’re going to do some of each. The question is what the mix is going to be.”

The good news is that measures to address climate change are also good for public health. The challenge, said Dr Jones, is to align health, equity and sustainability goals. But in New Zealand the political response to climate change has been stronger on rhetoric than reality.

New Zealand has shown an “extremely weak political response despite a clear need for strong, urgent global action.” Dr Jones blames powerful vested interests for preventing the necessary global responses to climate change.

Figure 10. New Zealand's climate change commitment...rhetoric not reality



Source: Parliamentary Commissioner for the Environment (2010,). *Lignite and climate change*.

States' international health rights obligations

Case studies analysis

Carmel Williams and Paul Hunt

Carmel Williams is a Research Fellow in the Centre for Development Studies, University of Auckland, and Executive Editor of "Health and Human Rights: An International Journal".

In General Comment 14, and in the Hunt analytical framework, attention is given to the obligations placed on developed countries to assist developing countries to realise the right to health. There is also a duty placed on third parties that they do not limit people's access to health-related information and services.

Specifically, there is a section in the Comment dedicated to international obligations. This builds on previous international agreements, such as the Alma-Ata Declaration on primary health care, and article 56 of the Charter of the UN, recognising the essential role of international cooperation because of "the existing gross inequality in the health status of the people, particularly between developed and developing countries" (Potts 2008, p13). State parties have to respect the enjoyment of the right to health in other countries, and must prevent third parties from violating the right in other countries. "Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required" (United Nations 2000).

Responding to Dr Percival's comments on the MDGs, and the need for States to identify, monitor and be accountable for their own right to health priorities and obligations, Professor Hunt said there is feeble accountability between developing and developed countries. He reiterated that states have a legal responsibility to ensure that their laws, policies, and activities support, and do not obstruct, the enjoyment of the right to health in other countries. This has relevance to trade, global warming, and to international development assistance programmes. Special attention is drawn to these responsibilities of multiparty, international agreements in General Comment 14.

In his UN report which addressed MDGs (United Nations 2000, s39), Professor Hunt urged that greater recognition of the right to health would enhance the Millennium Development initiative. He warned that it exhibited some of the features of the old-style, top-down, non-participatory approach to development:

The health-related Millennium Development Goals are framed in terms of societal averages, for instance, to reduce the maternal mortality ratio by three quarters (Goal 5). But the average condition of the whole population can be misleading: improvements in average health indicators can mask a decline for some disadvantaged groups. Because of this, human rights require that, so far as practical, all relevant data be disaggregated by the prohibited grounds of discrimination. In this way, it becomes possible to monitor the situation of vulnerable groups — women living in poverty, indigenous peoples, minorities and so on — and design policies that specifically address their disadvantage (United Nations 2004).

In his report, Professor Hunt warned that health-related MDGs are disease specific or based

on health status — malaria, tuberculosis, HIV/AIDS, maternal health and child health — and they would probably generate narrow vertical health interventions. “Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. Indeed, by drawing off resources and overloading fragile capacity, vertical interventions may even jeopardise progress towards the long-term goal of an effective, inclusive health system. A proper consideration of the right to health, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems available to all” (United Nations 2004).

This closely parallels Dr Percival’s observations in the Pacific where the MDG targets do not correspond to, and are insensitive measures of, child health priorities.

Referencing work by de Mesquita et al. (United Nations 2004), Professor Hunt emphasised the binding legal obligation placed on developed countries to provide international assistance. He conceded this is somewhat contentious, and whereas developing countries believe there is such a legal obligation, developed countries don’t. As Special Rapporteur, Professor Hunt observed, “If there is no legal obligation underpinning the human rights responsibility of international assistance and cooperation, inescapably all international assistance and cooperation fundamentally rests upon charity. While such a position might have been tenable in years gone by, it is unacceptable in the twenty-first century” (2010).

A duty has been placed on high-income states to urgently take measures toward devoting a minimum of 0.7 per cent of their gross national product to official development assistance. But the duty is not merely financial. States also have a responsibility to “work actively toward an equitable multilateral trade, investment and financial system conducive to the reduction of poverty and the realization of human rights, including the right to...health” (Bueno de Mesquita, Hunt et al. 2010, p112). Professor Hunt concluded by drawing attention to the three layers of obligation on states: to respect, protect and fulfil. “In the context of international assistance and cooperation in health, states must ensure that their actions respect the right to health in other countries. They must also, so far as possible, protect against third parties undermining the right to health in other countries. Depending on resource availability, states’ obligations to fulfil the right to health include responsibilities to facilitate access to essential health facilities and services in other countries” (Bueno de Mesquita, Hunt et al. 2010, p114).

The Comment also clarifies that while only States are parties to the Covenant (on economic, social and cultural rights), “all members of society — individuals, including health professionals, families, local communities, intergovernmental and non-governmental organisations, civil society organizations, as well as the private business sector — have responsibilities regarding the realization of the right to health” (Bueno de Mesquita, Hunt et al. 2010, p116). Furthermore, “In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health” (s42).

This has direct application to trade agreements, and the obligation to ensure such agreements do not result in regression of the realisation of people’s rights to health. Professor Hunt looked at trade agreements in Peru, and in his report to the UN cautioned that the US–Peru free trade agreement would limit access to essential medicines, especially for people living in

poverty. “The Special Rapporteur urges Peru to take its human rights obligations into account when negotiating bilateral trade agreements. He suggests that before any trade agreement is finalised, assessments identify the likely impact of the agreement on the enjoyment of the right to health, including access to essential medicines and health care, especially of those living in poverty. All stages of the negotiations must be open, transparent and subject to public scrutiny. In accordance with its human rights responsibility of international cooperation, the United States should not apply pressure on Peru to enter into commitments that either are inconsistent with Peru’s constitutional and international human rights obligations, or by their nature are “WTO-plus” (s39).

Professor Hunt, in response to Dr Jones’ presentation on climate change, agreed it represents an extremely grave risk to the health of individuals, communities and populations, especially those living in poverty in developing countries. He referred to States obligations arising from the right to health to take steps to slow down and reverse climate change. Further, the analytical framework can be applied to a rights-based response to climate change: “The vital importance of addressing climate change must be reflected in national budgets and international assistance and cooperation...Effective transparent and accessible monitoring and accountability mechanisms must be established...[with] responsibility to monitor, and hold all relevant public and private actors to account, in relation to national and international policies bearing upon climate change” (United Nations 2005, para 50-51).

Professor Hunt’s UN report on the right to health responsibilities of pharmaceutical companies is especially instructive when considering private sector human rights obligations (Hunt and Khosla 2009, p235). In this report he uses elements of the analytical framework to determine the role of the private sector in making medicines available, accessible, acceptable and of quality standards. “Enhancing access to medicines is a shared responsibility. If access to medicines is to be improved, numerous national and international actors have a vital role to play. The Millennium Development Goals recognize that pharmaceutical companies are among those sharing this responsibility. Goal 8, a global partnership for development, has a number of targets e.g. ‘In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries’” (United Nations 2009).

Returning to the themes of human rights accountability, in which the three layers of obligations, to respect, protect and fulfil the right to health must be demonstrated, in his time as the Special Rapporteur called for the development of a new tool — a “health system impact assessment” — that would assess the anticipated impact of a suggested intervention on a particular health system, as recommended by the Millennium Project Task Force 4 on Child Health and Maternal Health in its interim report.

Dr Carmel Williams presented a health systems impact assessment tool that she has designed and pilot tested. She said it provides a practical guide for any organisation wanting to engage in health work in a developing country context. Of critical importance, she argues, all international donors, State and non-state, need to assist the recipient State to meet their human rights responsibilities. In health, this means working with local health systems, because they are the core institution through which the right to health can be realised.

Dr Williams’ health systems impact assessment tool enables an organisation to assess the likely impact of new activities on all aspects of the health system. It uses the WHO ‘six blocks’ as the basic categories of the health system, and examines proposed activities against

each of the blocks to determine whether each activity would strengthen or weaken that block (Box 6).

Use of a rights-based tool reminds donors to ensure their proposed initiatives are in keeping with State plans and priorities, and in this way, assist the State to meet their human rights obligations. Vertical programmes (those that are not integrated into health systems) well funded by donors, risk harming health systems because they can attract health workers and use up funding, supplies and facilities that would otherwise have been used for essential, primary health services. Dr Teuila Percival's case study illustrated this with the MDGs demanding a focus on indicators that did not reflect the priority health issues of Samoa or Tonga.

At the very least, the impact assessment tool encourages donors to look beyond their immediate activities to consider the broader impacts of their work. It provides a means of enabling all health donors to work towards strengthening health systems and assisting states to meet their right-to-health obligations.

Box 6. Rights-based health system impact assessment tool

	Health services, goods and facilities
1	Does the programme enhance or jeopardise the availability, accessibility, acceptability and quality of all health goods, services and facilities?
2	Does the programme enhance or jeopardise the government's health care priorities as specified in the core obligations sections of UN ICESCR General Comment 14?
3	Does this programme address sustainability of services and goods developed to ensure ongoing availability, accessibility, acceptability and quality?
4	Has the community been consulted over this programme to assess whether it will make all health services more accessible and acceptable?
	Health workforce
5	Does the State have a national health-workforce strategy, and if so, is this policy in keeping with it?
6	Will this programme enhance or jeopardise the ratio and density of doctors available to the population to meet Core Obligations?
7	Will this programme enhance or jeopardise the ratio and density of nurses to the population?
8	What is the ratio of current health care professionals to the estimated need for a health workforce?
9	Does this programme address costs associated with the employment of additional staff and other health workforce sustainability issues?
10	Are the training components in keeping with a national health workforce training plan?
	Health information system
11	Does this programme address strengthening of the HIS?
12	Does this programme address collection of data and its integration into the HIS?
	Medical products, vaccines and technologies
13	Will medicines and products be added to the national medicines list as a result of this policy?
14	Has the cost to the government for additional medical products been addressed in this policy?
	National financing
15	Will implementation of this policy have a financial cost to the health budget?
16	Has this cost been accepted by the Department of Health and factored into future financial plans?
17	Will patients be charged user fees for this service?
18	Have user fees been discussed with patients?
	Governance and leadership
19	Does the State have a comprehensive national health plan encompassing public and private sectors?
20	Is the health care service addressed in this programme in keeping with the national health plan?
21	Were the government or health officials consulted in the development of this programme?
22	Are management systems and capacity sufficiently robust to withstand the additional workload from this new programme?

Highlights and conclusions

Carmel Williams

The right to health is a powerful tool in public health and international health. Historically it has been viewed more as a legal tool than one readily deployed by health professionals or planners. But this is now changing, and in no small way because of the work of Professor Paul Hunt during his time as Special Rapporteur on the Right to Health, and subsequently. In his numerous reports to the UN, and other publications, Professor Hunt has demonstrated the practical application of the right to health. In his own words, the right to health is no longer “a bumper sticker”.

Using key human rights concepts, the right to health has direct application to policy, to processes, to programmes and, if need be, to legal remedies. Traditionally the human rights approach was judicial, but now health workers can far more readily engage with health rights through what Professor Hunt calls “the policy approach”:

We need to think about what a programme looks like at district or national level, what will all this look like if it is grounded in equality, in dignity, in the right to health analytical framework, what will it look like, if we get all that right. Then we don't have to go to court...Going to court is an indication we have failed. Your policies and programmes will not be radically different from what you are already, if you are doing good stuff, but health rights can underscore what you are already doing, and it might help recognise or identify omissions.

Professor Hunt discussed the many preoccupations of human rights, including their proactive use, their role in process, importantly through ensuring participation, and their crucial role in accountability. “They are concerned with disadvantage, discrimination, inequality, and the need for active, informed, ‘bottom-up’ participation by individuals and communities.”

A crucial human rights preoccupation is effective, accessible, transparent accountability. Monitoring is very important, but it is not accountability, it is a pre-condition for accountability. Financial accountability is also extremely important, to ensure precious public funds are properly spent. But financial accountability is not *human rights* accountability. Human rights accountability is about ensuring that human rights commitments and values are honoured.

Accountability comes in many forms. For example, something as large and complex as a health system demands a wide range of accountability arrangements, such as parliamentary accountability, democratically elected health boards, an independent Health and Disability Commissioner, a free press, a robust civil society, judicial processes, and so on. Today, it is increasingly recognised that accountability arrangements should include (but not be confined to) an independent element for checking that human rights commitments and values are respected.

Importantly, human rights accountability is not about blame, sanction and punishment. It is about ensuring that what works is repeated, and what does not work is identified and revised — this is sometimes known as ‘constructive accountability’.

One important function of human rights accountability is to identify and highlight obstacles that hinder the realisation of human rights commitments and values in relation to the initiative under review, and then make practical recommendations about how the obstacles might be addressed.

Professor Hunt commented on Whānau Ora and its design, implementation and accountability in New Zealand. He considered Whānau Ora an interesting initiative which attempts to address the balance between the individual and collective:

From time to time, balances have to be struck between the individual and collective. This is natural, inevitable and need not be problematic. For example, under Whānau Ora, the whānau considers the health, lifestyles and well-being of all its members. However, in relation to some issues (e.g. some health issues), an individual might wish to maintain a degree of privacy. In such a case, a balance will have to be found between the individual's right to privacy and the legitimate collective interest and concern of the whānau. A human rights accountability arrangement can provide guidance on striking appropriate balances, when necessary, between the individual and collective.

Importantly, the right to health is not limited to health care: it also brings a rights imperative to the underlying or social determinants of health. Addressing inequity in these social determinants has sometimes been called an ethical imperative, but it is also a legal imperative. This is one element that a rights-based approach brings to public health: it brings “ethics with teeth”.

The right-to-health analytical framework provides a comprehensive and practical tool for people working in public health, health promotion, local and international health. As demonstrated throughout these workshops, this tool has application at every stage of a programme or policy: from design, to implementation, monitoring, evaluation, impact assessment and accountability. It has practical application in public health, programmes and policies. The framework enables health workers to translate the right to health into practice in process and outcomes. For processes, it promotes a transparent, participatory, and non-discriminatory approach to policy development and service provision. Right-to-health outcomes will be quality health care and determinants that are available, accessible, and acceptable to all. Human rights accountability encourages demonstration that these processes are followed, and the outcomes are achieved.

Use of the analytical framework will help all health workers become human rights workers, and accordingly play an essential role in the progressive realisation of the right to health.

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