LST REVIEW
Volume 17 Issue 232 February 2007

Prevention of Mosquito Breeding; the Bill and a Critique

Right to Health; a Comparative Overview and Peoples' Activism

LAW & SOCIETY TRUST

CONTENTS

Printed by:
Law & Society Trust,
3, Kynsey Terrace, Colombo 8
Sri Lanka
Tel: 2691228, 2684845 Tele/fax: 2686843
e-mail: lst@eureka.lk
Website: http://www.lawandsocietytrust.org

ISSN – 1391 – 5770

Editor's Note ... ...

The Right to Health has become a primary concern in Sri Lankan due to a variety of reasons, including most particularly lack of access to equitable health care, medically negligent practices on the part of government health service providers, lack of regulation and monitoring of health services and the absence of a medicinal drugs policy.

Some of these concerns were focused upon in the *LST Review*, Volume 16, Issue 219, January 2006 which published a Draft National Medicinal Drug Policy for Sri Lanka together with Charters on Health Rights/Patients' Rights and Responsibilities.

In a continuing discussion of these concerns, the *Review* publishes in this Issue, the Prevention of Mosquito Breeding Bill together with a comment on its contents by ***Dilhara Pathirana***. It must be said that our best efforts to obtain a copy of the Prevention of Mosquito Breeding Act (passed into law by Sri Lanka's Parliament on Feb 6th 2007) from the Government Publications Bureau and the Ministry of Health were to no avail and we were repeatedly informed that the Act was still with the government printer. This highlights the tremendous difficulties that Sri Lankans face in accessing enacted laws even months after they are passed by Parliament and is yet another illustration of the country's malfunctioning governance system. The analysis that the Review publishes is consequently, of clauses of the Bill.

A consistent thread running through this critical discussion is the absence of rigorous enforcement of statutory duties in regard to prevention of epidemic diseases on the part of the municipal and local authorities. While the laws in place enforce a number of such duties, their implementation is lackadaisical; this is a common phenomenon in many other areas of the governance process. Unlike in India, where public interest litigation has compelled the Government to redress its policies, laws and regulations relating to health care (even though the actual implementation of these revisions is still problematic), Sri Lanka is yet to see the law being taken from the statute books in order to afford relief to ordinary people who are the first victims of the negligence of the State. In this context, the announcement of yet another law, (the Prevention of Mosquito Breeding Act) that adds to the mass of statutes relating to public health is likely to be greeted with cynicism and not relief.

Further, the primary purpose of this most recent law appears to be the imposition of duties upon members of the public rather than upon errant government authorities. It must be emphasized that while householders should be subject to stringent obligations in regard to the disease prevention regime, the State has the primary responsibility thereof. Statutes such as the Health Services Act No 12 of 1952 (as

amended), Diseases (Labourers) Ordinance No.10 of 1912 (as amended), Veneral Diseases Ordinance No.27 of 1938; Mental Diseases Ordinance No.1 of 1873 (as amended) Contagious Diseases Ordinance No. 8 of 1866 (as amended) needs to be revised. Several provisions in the Local Authorities and the Nuisance Ordinance, the Municipal and Urban Council Ordinances and the Pradeshiya Sabha Act should also be strictly implemented. Deterrent sentences should be imposed for acts of omission or commission on the part of these authorities that negatively impact on public health.

The Review also publishes a useful comparative analysis of the right to health in a number of jurisdictions around the world by ***Iain Byrne*** who discusses decisions, most notably by the South African and the Indian judiciary in this regard. He makes the point that though the right to health, similar to other economic and social rights, is not always codified in domestic law, this does not mean that health rights are incapable of adjudication and enforcement by courts. His paper assesses various approaches to protecting health rights and suggests legal strategies for effective implementation.

Our final two excerpts focus on an imaginatively conceived public advocacy campaign around the world, spearheaded by the People's Health Movement (PHM) which grew out of a People's Health Assembly held in Bangalore, India in December 2000. The People's Health Charter which is published has now been translated into more than forty local languages throughout the world, including in Sri Lanka. A critical analysis of the progress of this movement which the Review publishes as its concluding segment illustrates both the strengths and the weaknesses of broad people-based movements such as the PHM.

Kishali Pinto-Jayawardena

Prevention of Mosquito Breeding

L.D.-O. 98/2002

AN ACT TO PROVIDE FOR THE PREVENTION OF MOSQUITO BREEDING AND FOR THE ERADICATION OF PLACES OF MOSQUITO BREEDING AND FOR MATTERS CONNECTED THEREWITH OR INCIDENTAL THERETO.

WHEREAS dengue fever and dengue haemorrhagic fever has become a major public health problem in Sri Lanka with the number of persons infected and dying of this disease increasing rapidly:

AND WHEREAS there is at present no vaccine available to prevent this serious disease nor is there any specific treatment to cure the disease:

AND WHEREAS the only method of preventing and controlling the spread of the disease is by destroying breeding places of the mosquito which spread the disease:

AND WHEREAS it has become necessary to effectively deal with this health problem from a national perspective by the formulation of a National Policy and by the appointment of a Competent Authority and other officers to be responsible for the implementation of the National Policy:

NOW THEREFORE be it enacted by the Parliament of the Democratic Socialist Republic of Sri Lanka as follows:-

Short title

1. This Act may be cited as the Prevention of Mosquito Breeding Act, No. of 2006.

Prohibition against creating conditions favourable to the breeding of mosquitoes.

2. For the purpose of ensuring the Prevention and eradication of all mosquito borne diseases, it shall be the duty of every owner or occupier of any premises to cause:-

(a) open tins, bottles, boxes, coconutshells, split coconuts, tyres or any other article or receptacle found in or within such premises, capable of holding water, to be removed destroyed or otherwise effectively disposed of;

(b) gutters, down-pipes and drains to be cleared of all obstructions, so as to allow a smooth flow of water;

(c) cisterns, tanks, air conditioners and other receptacles for water to be maintained in good repair, closed and covered so as to prevent the breeding of mosquitoes;

(d) any well found in the premises and its surroundings to be maintained and kept in good repair so as to make it mosquito-proof and thereby prevent the breeding of mosquitoes;

(e) any artificial pond or pool found in such premises to be emptied at least once in every week;

(f) any casual collection of water within the premises which is conducive to mosquito breeding, to be regularly drained;

(g) shrubs, undergrowth and all other types of vegetation, other than those grown for the purpose of food or those which are ornamental, found within or outside any building or structure within the premises used as a dwelling place which has become a breeding place for mosquitoes, to be removed;

(h) the removal and destruction of the water plants having the botanical name "Pistia Stratiotes" and commonly known as "Diya Parandel", "Kondepasei", "Telpassy", "Barawa-Pasi", "Nanayaviraddi" and of any other plant, found within the premises, which may facilitate the breeding of mosquitoes;

(i) the prevention of the spread of any plant referred to in paragraph (h), by the erection of suitable barriers where necessary, having obtained the approval of any relevant authority, which will stop such plant from floating along any water-course; and

(j) the elimination or the prevention of any other condition favourable to the breeding of mosquitoes, in or within the premises.

Owner or occupier to be directed to take certain measures.

3. (1) Where it appears to the Competent Authority, that any premises or anything kept or maintained therein has become favourable to the breeding of mosquitoes, the Competent Authority may by written Notice require the owner or occupier of such premises, to adopt or take any one or more of the following measures within the time specified in such notice:-

(a) the repair of all gutters, down-pipes and drains of any building found in that premises.

(b) the construction or reconstruction of any cistern, tank or artificial pond found in the premises in such manner so as to make it capable of being emptied periodically;

(c) to temporarily drain and clear any cistern, tank or pond found in the premises and the closing thereof when it is no longer being used by the owner or occupier of the premises;

(d) to maintain any well found in the premises in such condition so as to prevent the breeding of mosquitoes;

(e) to fill-up, drain or treat with larvicide, of any excavation, disused well, cesspit, pond or any other place where water is capable of being collected and stagnated;

(f) to fill up pits and low lying areas found within the premises;

(g) to fill-up or drain or treat once a week with larvicide, swamps and water courses and water logged are as found in the premises;

(h) remove, uproot and destroy water plants having the botanical name "Pistia Stratiotes" and commonly known as "Diya-Parandal", "Kondepasei", "Tel-Pasi", "Barawapasei", or "Nanayaviraddi" or of any other water plant or plants which may be found to afford breeding conditions to mosquitoes;

(i) prevent the spread of any water plant referred to in paragraph. (h), by the erection of suitable barriers which will stop such plant from floating along any water-course; and

(j) any other measures, the Competent Authority or any Public Health Inspector authorized in that behalf, may deem necessary.

(2) The written Notice referred to in subsection (1), shall further inform that in the event, the owner or occupier neglects or fails to comply with such Notice within the time specified therein, the Competent Authority shall be forced to carry out the measures specified in the Notice, and any expenses incurred in carrying out the same shall be recovered from such owner or occupier.

Failure to comply with requirements imposed by sections 2 or 3 to be an offence.

4. (1) Every owner or occupier who contravenes or fails to comply with any duty or requirements imposed by sections 2 or 3 of this Act, shall be guilty of an offence under this Act and shall on conviction after summary trial before a Magistrate, be liable to a fine not less than one thousand rupees and not exceeding twenty five thousand rupees and in the case of a continuing offence, to a fine of one hundred rupees for each day on which such offence is continued to be committed after conviction:

Provided that no such owner or occupier shall be deemed to be guilty of that offence, if such owner or occupier proves to the satisfaction of the Magistrate, that such offence was committed without his knowledge or that he exercised all due diligence to prevent the commission of such offence.

(2) The Magistrate may, where the person is found guilty of having failed to comply with a duty imposed by section 2 of this Act, in addition to the imposition of the fine referred to in subsection (1), require such owner or occupier to take such preventive or corrective measures as the, Magistrate may deem appropriate in order to prevent the breeding of mosquitoes, in compliance with the duties imposed on such owner or occupier by that section.

Competent Authority to carry out work or measures.

5. (1) Where the owner or occupier of any premises on whom any written Notice has been issued under section 3 of this Act, neglects or fails to comply with the requirements of such written Notice within the time specified therein, the Competent Authority may authorized in writing any officer or officers, as the case may be, to enter such

premises at any reasonable hour during the day and carry out the work or measures specified in the Notice which the owner or occupier has neglected or failed to do. Prior to commencing any work or measure under this subsection, such officer or officers shall be required to show the owner or occupier, a copy of the document issued by the Competent Authority by which such officer or officers were authorized to carry out such work or measure.

(2) Nothing contained in subsection (1) shall preclude an owner or occupier who failed to comply with a Notice issued, from being prosecuted for an offence under section 4 of this Act.

(3) Where any works or measures are adopted or executed under subsection (1), the amount of expenses incurred as cost shall be payable by the owner or occupier to the Competent Authority, within two weeks of the date on which the demand for payment of the same was communicated to such owner or occupier.

(4) Where the owner of any premises in respect of which a sum of money is due and owing under subsection (2) of this section, sells or transfers such premises before payment of the money due, such owner shall, notwithstanding the sale or transfer of such premises, continue to be liable to pay the amount due.

Recovery of expenses incurred as cost under section 5.

6. (1) Where the owner or occupier, fails to make the payment within two weeks of the demand for payment being communicated to him under subsection (3) of section 5, the Competent Authority shall issue a Certificate containing particulars of the amount due as expenses incurred in carrying out such work or measures, to the Magistrate having jurisdiction over the area in which such premises are situated.

(2) The Magistrate shall thereupon summon such owner or occupier, as the case may be, to appear before when and show cause why further proceedings for the recovery of the amount due should not be taken against him and in default of sufficient cause being shown, the amount shall be deemed to be a fine imposed by a sentence of the Magistrate on such owner or occupier, for an offence punishable with a fine only or not punishable with imprisonment.

(3) Where the Competent Authority issues a Certificate under subsection (1), he shall also cause a notification thereof to be issued to the relevant owner or occupier. Non-receipt of a notification issued to an owner or occupier, shall not invalidate any proceedings under this section.

(4) Nothing in this section shall authorize or require a Magistrate in any proceedings there under, to consider, examine or decide the correctness of any statement contained in the Certificate issued by the Competent Authority.

(5) Any sum levied as a fine under subsection (2), shall be transmitted by the Magistrate to the Competent Authority.

Spraying of pesticides.

7. (1) The Competent Authority may by notice in writing served on any owner or occupier of a premises, require such owner or occupier to

spray any pond, cistern, fountain or any other place where gets water collected and where mosquitoes are found to be breeding, with such type of pesticide as specified in such notice and within the time specified therein.

(2) The failure to comply with a notice issued under subsection (1) within the time specified, shall be an offence under this Act, and on conviction after summary trial before a Magistrate, such owner or occupier shall be liable to a fine not exceeding one thousand rupees.

Resisting or obstructing Competent Authority etc.

8. (1) No owner, occupier or any other person shall knowingly or willfully, resist or obstruct the Competent Authority or any person to whom he has delegated the performance or discharge of any of his duties or functions under this Act, in the lawful performance or discharge of any of his duties or functions under this Act, in the lawful performance or discharge of those duties or functions.

(2) Any owner, occupier or any other person who acts in contravention of the provisions of subsection (1) of this section shall be guilty of an offence under this Act, and on conviction after summary trial before a Magistrate, be liable to a fine not exceeding fifty thousand rupees or a term of imprisonment not exceeding six months, or to both such fine and imprisonment.

Lessening the efficiency of any measures adopted.

9. (1) An owner or occupier or any other person shall not knowingly or willfully commit any act which is likely to –

(a) cause the deterioration of any anti-mosquito measures carried out or adopted in any premises; or
(b) lessen the efficacy of any anti-mosquito measures carried out or adopted in any premises,

whether such measures were carried out or adopted by the owner or occupier of the premises or by the Competent Authority.

(2) Any owner, occupier or any other person who acts in contravention of the provisions of subsection (1), shall be guilty of an offence under this Act, and on conviction after summary trial before a Magistrate, be liable to a fine not exceeding ten thousand rupees or a team of imprisonment not exceeding three months or to both such fine and imprisonment.

Co-owners and co-occupiers to be liable severally.

10. Where any premises are in the occupation of more than one person or where any property is co-owned by more than one person, for the purpose of the enforcement of the provisions of this Act, each of the occupiers and each of the co-owners shall be severally liable for any neglect or failure to comply with any requirements imposed by or under this Act.

Protection for an act or omission done or purported to be done in good faith.

11. No suit or prosecution shall lie against an owner or occupier of a premises, for any act or omission which is done or purported to be done in good faith.

Directions to be issued to local authorities who fail to maintain drains, canals & c,. which they are required t maintain.

12. (1) Where any drain, canal, water course or swamp found within the administrative limits of a local authority which such authority is required to maintain in proper condition, is found to have become conducive to the breeding of mosquitoes due to the failure or negligence on the part of such local authority to maintain the same in proper condition, the Competent Authority shall have the power to issue such directions as he may consider necessary or appropriate, to rectify such situation and prevent the breeding of mosquitoes.

(2) A local authority which fails to comply with any directions issued under subsection (1) shall be guilty of an offence under this Act, and any prosecution for such an offence instituted by the Competent Authority, shall be filed against the Chairman of such local authority or any other competent authority appointed under any law relating to local authorities to act on behalf of that local authority.

Power of entry and inspection.

13. (1) Subject to the provisions of subsection (2); the Competent Authority shall, have the power to enter any premises at any reasonable time –

(a) to carry out any survey, inspection or search, for the purpose of determining whether -

(i) any duties imposed by section 2 of this Act are being complied with by the occupier or owner of such premises; or

(ii) any measures are necessary, and if so, the extent to which they are necessary, for the elimination or the prevention of the breeding of mosquitoes.

(b) to execute any work or measures required to be carried out under section 5 of this Act.

(2) For the purpose of carrying out any survey, inspection or search under subsection (1), written consent to enter the premises shall be obtained –

(i) where the premises concerned is a place of religious worship or is a place not open to the public, from the person in charge of such premises or any other competent person; or

(ii) where the premises concerned is used as a place of private residence, from the owner or occupier of such residence.

(3) Where a consent that is required to be obtained under subsection (2) is unfairly refused and the Competent Authority is satisfied that there is reason to suspect that any requirement imposed under this Act is not being complied with, the Competent Authority may obtain from a Magistrate's Court a search warrant for the purpose of entering such premises or private residence, as the case may be, and exercise all or any of the powers conferred upon him by such search warrant.

Competent Authority and delegation by the Competent Authority.

14. (1) The Director-General of Health Services shall be the Competent Authority for the purposes of this Act and shall be charged with the effective implementation of the provisions of this Act.

(2) The Director-General of Health Services may, whenever he considers it necessary and expedient, delegate the performance or discharge of any duty or function imposed upon him by this Act in his capacity as Competent Authority, to a Medical Officer of Health or to a Public Health Inspector in any area, and the officer to whom the duty or function was so delegated, shall perform or discharge the same subject to the control and supervision of such Competent Authority.

(3) An officer to whom a delegation is made under subsection (2) of this section shall, in the performance and discharge of the duties and functions so delegated, exercise the same power of entry and inspection as given to the Competent Authority under section 13 of this Act, and any obstruction caused to such officer shall be an offence under section 8 of this Act.

(4) The Competent Authority may give such directions as he may deem necessary, to any Public Health Inspector or Medical Officer of Health with regard to the effective implementation of the provisions of this Act and any regulations made thereunder and every such officer to whom any such directions are given, shall be required to comply with the same.

Offences to be Cognizable offences.

15. Notwithstanding anything to the contrary in the Code of Criminal Procedure Act, No. 15 of 1979, every offence under the Act, shall be deemed to be a cognizable offence within the meaning and for the purposes of that Act.

Prosecutions under this Act to require sanction.

16. A prosecution for any offence under this Act, shall not be instituted except with the sanction of the Competent Authority or the Medical Officer of Health of the area where the offence is alleged to have been committed.

Prosecution procedure.

17. (1) Where an offence is found to have been committed under this Act by an owner or occupier, prior to a prosecution being instituted, a Public Health Inspector shall be required to serve a written notice upon the alleged offender requiring such person to adopt or take such corrective measures as shall be specified in such notice, within two weeks of receipt of the same. A person upon whom a notice is served under this subsection, may request for an extension of time within which to adopt or take the corrective measures required, and the Public Health Inspector may, in consultation with the Medical Officer of Health of the area, grant or refuse to grant such extension. No extension shall be granted beyond a period of a further two weeks.

(2) On the expiry of the time granted for adopting or taking the required corrective measures under subsection (1), the Public Health Inspector who served the notice shall inspect the measures adopted or taken, and within one week of carrying out the inspection, submit a report on the same to the Medical Officer of Health of the area. In the report submitted, the Public Health Inspector may, where he considers it necessary, recommend proceeding being instituted against the alleged offender.

(3) Where the Public Health Inspector recommends proceedings being instituted, the Medical Officer of Health shall, subject to the provisions of subsection (4) of this section, grant sanction for the same within one week of the receipt of such recommendation.

(4) A Medical Officer of Health to whom a recommendation for the institution of proceedings has been made under subsection (2) may, where he considers on the information contained in the report submitted along with such recommendation, that the institution of proceedings so not warranted, shall be required himself to inspect the measures adopted or taken by the alleged offender and submit his own recommendations on the same, to the Competent Authority. The Competent Authority shall within two weeks of receiving the recommendation, arrive at a final decisions as to whether prosecution should or should not be instituted against the alleged offender.

Competent Authority etc. to be peace officers.

18. The Competent Authority and any person to whom any of his functions and duties has been delegated shall, in the discharge and performance of such function or duty, be deemed to be peace officers within the meaning of the Code of Criminal Procedure Act, No. 15 of 1979, for the purpose of exercising any of the powers conferred upon peace officers by that Act.

Service of notices.

19. Any notice required to be served on an owner or occupier of a premises under sections 3, 7 or 17 of this Act, may be effected either personally by handing over such notice to the owner or occupier, of the premises or by affixing such notice in a conspicuous place within the premises.

Act to bind the Republic etc.

20. The provisions of this Act shall apply to and shall bind the Republic and any Ministry or Department of the Government of Sri Lanka.

Protection for action taken under this Act.

21. No civil or criminal proceedings shall be instituted against the Competent Authority or against any Medical Officer of Health or Public Health Inspector to whom the performance or discharge of any function or duty imposed upon the Competent Authority by this Act has been delegated under subsection (2) of section 14 of this Act, for any act which in good faith is done or purported to be done by such Medical Officer of Health or Public Health Inspector, as the case may be.

Offences committed by a body of persons.

22. Where an offence under this Act is committed by a body of persons, then –

(a) if that body of persons is a body corporate, every director, manager or secretary of that body corporate;

(b) if that body of persons is a partnership, every partner of that partnership;

(c) if that body of persons is an unincorporated body, every individual who is a member of that body; and

(d) if that body of persons is a local authority, the Chairman of such local authority or any other competent authority appointed under any law relating to local authorities to act on behalf of that local authority:

Provided that any person referred to in paragraphs (a), (b), (c) and (d) above shall not be deemed to be guilty of such offence, if such person proves to the satisfaction of the court that such offence was committed without his knowledge or that he exercised all due diligence to prevent the commission of such offence.

Regulations.

23. (1) The Minister may make regulations for the purpose of carrying out or giving effect to the principles and provisions of this Act.

(2) In particular and without prejudice to the generality of the powers conferred by subsection (1), the Minister may make regulations for all or any of the following purposes:-

(a) issuing guidelines as to the form of any notice required to be sent by the Competent Authority to any owner or occupier under this Act;

(b) recommend the measures to be taken and the type of pesticides to be used by an owner or occupier of any premises to eradicate the breeding of mosquitoes;

(c) issuing guidelines on Anti-Mosquito measures to the Anti-Malaria Campaign and any other similar Agency functioning under the Ministry, for the prevention and eradication of the breeding of mosquitoes.

(3) Every regulations made by the Minister shall be published in the *Gazette*, and shall come into operation on the date of such publication or on such later date as shall be specified in the regulation.

(4) Every regulation made by the Minister shall as soon as convenient after its publication in the *Gazette*, be brought before Parliament for its approval.

(5) Any regulation which is not so approved shall be deemed to be rescinded as from the date of such disapproval, but without prejudice to anything previously done thereunder.

(6) The date on which any regulation shall be deemed to be so rescinded, shall be published in the *Gazette*.

Sinhala text to prevail in case of inconsistency.

24. In the event of any inconsistency between the Sinhala and Tamil texts of this Act, the Sinhala text shall prevail.

Interpretation

25. In this Act, unless the context otherwise requires –

"Director-General of Health Services" means the Director of Health Services appointed under section 3 of the Health Services Act (Chapter 219);

"Medical Officer of Health" means any officer appointed to the designated post of Medical Officer of Health in the Department of Health Services or any officer acting in that post, and includes a Chief Medical Officer of Health, a Deputy Chief Medical Officer of Health, a Deputy Chief Medical

Officer of Health and a Medical Officer of Health in the service of a Municipal Council serving within the administrative limits of such Council;

"occupier" means a person in occupation of any premises or having the charge, management or control thereof, whether on his own account or as an agent of any other, but does not include a lodger;

"owner" includes a co-owner, a lessee, any person who by whatever right is entitled to the rent or produce of any premises and any individual, institution, body corporate or official who is responsible for the proper maintenance of the premises;

"premises" means any land together with any building or part of a building standing thereon; and

"Public Health Inspector" means any officer appointed to such post in the Department of Health Services and includes any Public Health Inspector of a local authority, who is authorized by the Competent Authority to perform any function as a Public Health Inspector under this Act.

Public Health in Sri Lanka; Obstacles in the Prevention of Vector Borne Diseases

Dilhara Pathirana[*]

Introduction

Public health is an essential component of healthcare services provided by the State. It is an aspect of health services concerned with threats to the general health of the community which includes surveillance, prevention and control of infectious diseases and particularly mosquito borne diseases that are widely prevalent in a tropical country like Sri Lanka.

However, public health (especially the control/prevention of vector borne diseases) has received scant attention from a notoriously inept and inefficient local authority riddled with corruption and hampered by financial constraints.

The total breakdown in the public health sector was graphically brought to the fore in recent months with an island wide outbreak of *chikungunya* a mosquito borne viral flu afflicting an unprecedented number of people causing severe pain and discomfort and bringing their day to day activities to a halt, (see annexure to this study). Although *chikungunya* is not as potentially fatal as dengue, it can be a severely debilitating disease. There is no vaccine or medicine for this viral flu and the patient has to recover naturally.

It is well known that both *chikungunya* and dengue are mosquito borne diseases caused by poor environmental conditions and high pollution levels which offer ideal conditions for the breeding of disease carrying mosquitoes. In a country with a more civic minded and public spirited people, the sheer magnitude and ferocity of the epidemic would have led to class action law suits being filed against local authorities for dereliction of duty.[1] However, such patterns of activism have not been evidenced in Sri Lanka.

The existing legal regime

It is pertinent at this point to ponder on the existing/intended laws that are in force to protect and promote public health. The scope of this article does not attempt to cover the whole ambit of public health[2] but deals specifically with existing/intended laws and other relevant issues that encompass the prevention and containing of mosquito/vector borne diseases like *chikungunya* and dengue; this being an area of public health which has been woefully neglected by the health authorities in this country.

---

[*] attorney-at-law, researcher, Law and Society Trust

[1] *The Nation*, 31/12/06

[2] For a comprehensive discussion on these aspects, see '*The Right to Health as a Socio-Economic Right in Sri Lanka – its scope and limits*' by Dr J de Almeida Guneratne, P.C. in the State of Human Rights in Sri Lanka (Annual Report) published by the Law and Society Trust of Sri Lanka – 2005.

Public health is an area in which local authorities play a central part since it is linked to providing basic services like garbage disposal, cleaning of drains and other water ways and provide other sanitary services that prevent the breakout of diseases.

Various local authority laws contain provisions relating to public health and sanitation. However, the responsibility of the enforcement of these laws is with different agencies without any overall coordinating mechanism. There is no office at a national level such as that of the Commissioner of Public Health.[3] The Municipal Council Ordinance stipulates the powers and duties of MCs relating to repairing/cleaning/emptying drains, removal of household refuse. It is under a duty to provide places for the sanitary disposal of garbage.

The MC also makes provision for a municipal magistrate who shall try/determine any offences against persons who keep his/her premises/environment in an unsanitary state. The Urban Council Ordinance contains similar provision relating to public health and sanitation. At the time of its enactment, the Pradeshiya Sabha Act of No 15 of 1987 was to play a pivotal role in the area of public health and sanitation. For instance, the Act enables the pradeshiya sabhas (local authorities) to pass by-laws in relation to a variety of subjects such as sanitation and public health. Among such duties include the prevention of malaria and the destruction of mosquito and disease bearing insects; the draining, cleansing, covering or filling up of ponds, pools, open ditches, sewers, drains and other places containing or used for the collection of any drainage, filthy water, matter or other thing of an offensive nature likely to be prejudicial to health.

However, the numerous pradeshiya sabhas in the country have routinely failed in implementing these vital preventive duties Thus, this piece of legislation, which was intended to play an important part in preserving public health, has failed in its actual improvement of the state of public health.

Duties of Municipalities

In recent times, given the dengue and *chikungunya* epidemics in cities, including Colombo, the Colombo Municipal Council (CMC) and other Municipal Councils which are in control of large densely populated areas, have been severely critiqued in respect of their health safety policies. Colombo's Municipalities have lacked proper garbage disposal systems for years. A proper waste management system, which is vital for an efficient and the safe disposal of garbage, is virtually non-existent. The CMC routinely dumps garbage/rubbish on marshy or unused lands, totally disregarding the resultant health problems. Indeed, both local governments and municipal councils have been directly responsible for many of the largest mosquito breeding areas. There have been frequent protests from the public in regard to the dumping of garbage near residential areas and the failure to clean stagnant canals, sewerage sites and other pits and potholes filled with filthy water.

At one point, the CMC had entered into an agreement with a private Company named Burns Environment & Technologies Ltd. (BETL), which collected garbage from one dumping site to process as compost manure. A dispute with the company however resulted in court proceedings leaving the site full and unable to accommodate anymore waste. The deputy mayor at that time, who was

[3] Jayasuriya, D.C. & Jayasuriya, S., Health legislation system in Sri Lanka

interviewed on January 18th 2006,[4] was reported to have said that the court case was continuing and that there was no resolution in regard to the problem of garbage disposal. This dispute exemplifies a common problem in the handling of waste by municipalities in the country.

Meanwhile, the risks inherent from the population explosion in the city which still has its old waste disposal systems in place with little capacity to provide for the rapidly increased population has been adverted to by senior officials of the municipal administration. Dr Pradeep Kariyavasam, the head of the CMC's public health department has drawn particular attention to attendant health risks, including plague and dengue fever.[5] The CMC's medical officer has however, refuted allegation of negligence attributed to municipal authorities by citing several preventive and other measures taken by the Council, including the spraying of larvicides for mosquito control to roadside public drains when sometimes rain water collects with no drainage in high risk areas.[6]

Chikungunya had been allegedly imported into the island by travelers/refugees from India as India had been having *chikungunya* for sometime. Yet, checks at the airport and in Mannar when refugees arrive from the Indian coastline were minimal. In regard to the most recent spread of the disease, the country's national surveillance system could not identify the epidemic and consequently the CMC was not informed, for some months. Once confirmation had come in, the CMC's defence was that it responded expeditiously by public awareness campaigns such as publishing leaflets and banners, advising residents regarding the elimination of breeding places in which the *chikungunya* and dengue mosquitoes thrive and keeping their surroundings clean. The prevalent CMC defence was therefore that their workers had been tirelessly engaged in the most vulnerable and mosquito prone areas creating awareness, collecting containers, spraying the canals and drains, fumigating underground drains, carrying out residual spraying to keep the number of patients to a minimum. However, the extent of the preventive measures that have been resorted to, have been critiqued as insufficient and inadequate by citizens who live in areas where the *chikungunya* epidemic was prevalent.[7]

The Government Entomological Assistants Union, whose members study insects and their links to various diseases, has blamed successive governments for ignoring their surveys and not using their technical expertise.[8]

Cuts in Public Health

Many of the special control programs carried out in Sri Lanka have failed as a direct result of decentralization and drastic cuts in funds. These special programs are said to be functioning only in an advisory capacity. The funds that are allocated for prevention of diseases are extremely low. In order to contain epidemics, a national level control programme with sufficient funding and manpower is needed.

In the past, (1950 – 1970s) the central government contributed funds so that the local authorities could maintain public health services and infrastructure at a satisfactory level. In recent years, however, the

[4] The Socialist Web, http://www.wsws.org/articles/2006/feb2006/sril-f07.shtml)
[5] http://www.wsws.org/articles/2006/feb2006/sril-f07.shtml, The World Socialist Web.
[6] The *Island*, 18.1. 07
[7] Island 12/1/07
[8] http://www.wsws.org/articles/2004/deng-;16.shtml

government has started cutting back drastically on funds in order to reduce its budget deficits and implement the economic reform program recommended by the IMF and the World Bank. In its budget for 2003, for instance, the CMC hoped that the government would grant Rs. 640, 77 million. But the actual amount received was a mere Rs 398.71 million. In 1970, government grants constituted 25.4% of the CMC's total revenue, however, the percentage for 2004 and 2005 were 16.9 and 16.6 respectively.[9]

The CMC has complained of financial constraints and lack of staff to deal adequately and effectively with preventing/controlling epidemics. There are only 65 labourers for chemical spraying and until recently the CMC had only 18 public health inspectors and 20 field assistants while the required cadres were 58 and 70 respectively. The Colombo Municipal Council has only seven fumigating machines to spray in high risk areas and only eight men to operate them, although the required number of machines is 25. The budget of the CMC does not make it possible for it to communicate educative messages in the electronic media and the press. TV companies charge exorbitant sums with the available resources. Advertising even in the state owned media is not possible.

While complaints of insufficient resources are common on the part of municipalities, even where funds are, in fact, available, massive corruption and wastage have resulted in these resources not being diverted to the protection of public health.

Comparative Experiences

Countries which have managed to successfully control the mosquito menace in the past, for instance Cuba and Singapore, have shown strong political will and commitment in their campaigns, ensuring a high level of community support in support of a comprehensive mosquito borne disease control program and necessary legislation.

Epidemic control programs closer to home also furnish good examples of an integrated approach to these problems. South Asia, a densely populated region with its tropical climate is frequently subjected to vector borne diseases such as dengue, malaria and *chikungunya*. In late August 2005, a triple epidemic of dengue, malaria and *chikungunya* began to spread in different parts of India and created quite a stir within the country and in the region. The gravity and the magnitude of this public health crisis brought key issues such as the health system's inadequate response to the mosquito borne diseases into the forefront.

When North India (and the capital Delhi, in particular) was affected by dengue, *chikungunya* was spreading in the South, especially the states of Andhra Pradesh, Tamil Nadu, Karnataka and Kerala, while people in Maharashtra which is supposed to have eradicated malaria sometime ago, were once again inflicted with the disease.[10]

In India, public outrage at the scale of the epidemic resulted in the Petitions Committee of the Delhi Assembly holding the Municipal Corporation of Delhi and the Delhi Jal Board responsible for the outbreak of dengue and vector borne diseases in the capital, one of the worst affected areas. The

[9] (http://www.wsws.org/articles/2006/feb2006/sril-fo7.shtml
[10] The Island, 26/10/06

corporation's failure to effectively de-silt open drainages has provided breeding grounds for mosquitoes and insects that have resulted in diseases like dengue, *chikungunya* and malaria was severely castigated. Responding to the public health crisis affecting India, the director of the National Vector Borne Disease Control Program of India stated that the plan is to have a three pronged dengue prevention strategy based on international experience and WHO guidelines.

In the Action Plan for this year (2007), apart from strengthening the existing system, which includes door-to-door surveillance, activities for community awareness, officials in the National Vector Borne Diseases Control Board (NVBDCP) have proposed several other measures to be introduced and tested for the first time in the country for curbing/controlling the disease. The NVBDCP has proposed a plan to call experts from Malaysia, Korea, Singapore and Vietnam for training the doctors since these countries have been able to control and treat vector borne diseases more effectively.

The NVBDCP officials intend to coordinate with the Urban Development Ministry and the Ministry of Environment since these two institutions too are closely linked to the controlling of mosquito borne diseases. The NVBDCP has proposed that the environmental ministry makes it mandatory for contractors to seek a certificate stating as to whether the building creates mosquito-genic conditions prior to construction on any project commences. Thus commercial activities cannot commence unless the contractors obtain an environmental impact assessment (EIA) report from the Environment Ministry. Likewise, a certificate would be issued that the building will not create mosquito-genic conditions before the construction starts. This requirement in the law is meant to result in householders being more responsible as well.[11]

The Indian Government has thus wisely adopted a multi-pronged approach involving all relevant ministries so that mosquito borne diseases could be effectively controlled.

The Prevention of Mosquito Breeding Bill[12]

The growing menace of mosquito borne diseases and the inability of local authorities to effectively control and prevent occurrences of these epidemics especially within municipal areas, has prompted Sri Lanka's central government, namely the Ministry of Health to put forward a bill titled the "the Prevention of Mosquito Breeding Act."

Even though the local authorities already have powers vested in them by laws and regulations to deal effectively with the prevention of such diseases, the enactment of this law was apparently to spearhead a more concentrated campaign to safeguard public health. According to the Minister of Health, Nimal Siripala de Silva, this Bill had been initiated on the recommendation of health experts and on the recommendations of the Epidemiological Unit of the Ministry of Health.[13]

The preamble to the bill clearly states that the mosquito borne viral fever, specifically dengue is a major health problem and the non-availability of a vaccine or any specific method of treatment compounds the problem. It also draws attention to the increasing mortality and morbidity rates as a

---

[11] http://www.indianexpress.com/story/20235.htl

[12] the following analysis will look at clauses of the Bill which was passed into law by Sri Lanka's Parliament on Feb 6th 2007.

[13] Daily News, 7/2/07

result of the spread of these vector borne diseases and the vital importance of destroying breeding places of the mosquito in order to prevent and control the spread of the disease.

The bill acknowledges the necessity of dealing with this specific public health problem at a national level by the formulation of national policy and the appointment of a Competent Authority to implement the national policy. With the enactment of this bill, there will be one overseeing central authority in charge of this area of public health which had previously been almost entirely handled more or less by the local government authorities like the Municipal Councils, Urban Council and Pradeshiya Sabhas.

Clause 2 of the bill places the duty and responsibility on the owner/occupier of premises to remove/destroy or otherwise effectively dispose of all containers like tins, bottles, boxes etc which may hold water which provide breeding places for mosquitoes; clean rain water gutters drains and a host of other duties related to the elimination and eradication of mosquito breeding places. The "owner" of premises in this section also includes an institution or body corporate. Thus premises of government departments, recently highlighted in the press as prime mosquito breeding areas come within this duty of care imposed by Clause 2 of the bill.[14] According to Clause 2 and several other subsequent sections of the bill, public/community cooperation seems to have been uppermost in mind of the framers of the bill as an essential prerequisite in curbing and preventing mosquito borne diseases. While it must be conceded, that public cooperation is vital, the public health authorities too should take a proactive role in collaborating with the public in the prevention and control of such diseases.

Under clause 13 (1) of the Act, the Competent Authority is authorized with the powers of entry and inspection of premises in order to determine whether any duties imposed by clause 2 of the bill are complied with by the owner/occupier of the premises, and if certain measures are necessary to be carried out by the Competent Authority for the eradication of mosquitoes, to determine as to what extent they are required.

Clause 4 of the bill stipulates the penalty for the failure on the part of the owner/occupier of premises to comply with duties imposed by clauses 2 and 3. Under clause 3 of the bill, if the occupier/owner fails in his statutory duty of keeping his/her environment/premises free from the breeding of mosquitoes, the Competent Authority himself can take measures such as repairing drains, gutters and all other clean up operations which help in eradicating and preventing the breeding of mosquitoes. The bill specifies that the cost of such repairs, clean ups shall be recovered from the owner/occupier of the premises. However, the income levels, financial constraints of the owner/occupiers of such premises do not seem to have been considered. For instance, shanties/urban slums (which would come within the definition of "premises" as used in the bill) are some of the most vulnerable mosquito prone areas. It is unrealistic and impractical to expect occupiers/owners of such ramshackle dwellings having the financial means to bear expenses for such repairs and clean ups. In such instances, government assistance would be required if the purpose of the Act is to be achieved.

Under clause 7 (1), the Competent Authority has a discretion to require an owner/occupier by written notice to spray any pond, cistern or other place where water gets collected and where mosquitoes are

[14] The Morning Leader, 20.12.06

found to be breeding, such pesticide that maybe prescribed in the notice. A failure by the occupier/owner to comply with such notice shall be an offence and on conviction the owner/occupier would be liable to a fine.

Clause 9 of the bill states that an owner/occupier of any premises who wilfully commits acts likely to cause the deterioration of any anti-mosquito measures carried out or adopted in any premises and thus cause to lessen the effectiveness of any anti-mosquito measures, shall be guilty of an offence and punished according to the provisions of the Act.

Thus even a cursory examination of the bill reveal that there is a great deal of emphasis placed on the duty of the public in clearing and eradicating mosquito breeding places; while public health authorities, specifically local authorities like Municipal Councils, Urban Councils etc do not seem to have been conferred much responsibility in this regard, judging from the provisions of the bill.

Clause 12 of the Prevention of Mosquito Breeding bill is important as it empowers the Competent Authority to take legal action against local authorities who fail in their duties relating to public health, namely the eradication and control of mosquito breeding places. This provision takes on an added significance since the insertion of this section by the framers of this bill is a tacit acknowledgement by the central government that the local authorities have failed on many occasions to act on their own initiative and carry out the duties vested in them.

According to clause 12 any drain, canal, water course or swamp found within the administrative limits of a local authority of which it is in charge is found to be conducive to the breeding of mosquitoes due to the failure or negligence on the part of such local authority to maintain these places in a proper condition, the Competent Authority shall have the power to issue such directions as he may consider necessary to rectify such a situation and prevent the breeding of mosquitoes.

On a careful examination of this section it becomes apparent that the local authority could be found to be in breach of its statutory duty only in relation to unsanitary drains, canals water courses, swamp. While it is true that these are the most obvious places for mosquitoes to breed, one should not forget the unsightly and very unhygienic garbage dumps along roadsides within municipal limits, which are potential breeding places for mosquitoes. Garbage dumps contain empty cartons, yoghurt cups and other discarded containers in which water collects and thus contributes to mosquito breeding.

Conclusion

In order to prevent and control vector borne diseases, public health experts recommend an integrated approach, which includes various mosquito controlling methods. The methods against mosquito larvae include environmental, chemical and biological methods while methods against adult mosquitoes mainly include chemical and genetic methods. A common point made in this regard is that, in order to contain epidemics of this proportion, it is vital to deal with this public health problem at a national level, since the cooperation and coordination at central, local and provincial level was necessary in the prevention and control of these diseases. This integrated policy approach has not been apparent.

The Government has been quick to lay the blame squarely on ordinary people/the public for not eradicating mosquito breeding sites and not keeping their surroundings clean. Government authorities seem to view the spread of dengue/vector borne diseases as inevitable unless there is full public cooperation in maintaining sanitary conditions. While it cannot be disputed that public cooperation is vital in any preventive healthcare programme, the central government and the local authorities cannot absolve itself from the vital role it plays in protecting public health. Vector borne diseases can be prevented or at least controlled to a large extent. The reasons for the spread of such diseases to reach epidemic proportions stem from poor sanitation, ineffective government preventive measures and financial cutbacks to public health. An integrated health policy program which addresses all these concerns is a must for Sri Lanka.

Annexure – data report from *The Epidemiological Unit of the Ministry of Health* - http://www.epid.gov.lk,

Investigation of the Outbreak of Chikungunya Fever – 2006/7 Sri Lanka

Background

Since mid October 2006 there have been several reports to the Epidemiology Unit, Ministry of Health Sri Lanka of an increase in viral fever cases from numerous sources. These sources included some general practitioners from Colombo district, mostly from the Colombo Municipal Council area, regional epidemiologists and physicians from private sector and from districts of Kalmunai, Mannar, Batticoloa and Jaffna. This viral fever was characterized with high fever, severe joint and muscle pain and a maculopapular rash. Arrangements were promptly made to send samples of blood from these patients for virological studies on dengue, measles and rubella to the Medical Research Institute (MRI), Colombo. Since the samples tested negative for these diseases it was decided to subject them to virological studies on Chikungunya which caused a recent outbreak in India. The samples were tested for Chikungunya at MRI, Molecular Medicine Unit of the Department of Microbiology at University of Kelaniya, Gene-tech Research Institute Colombo, Armed Forces Research Institute of Medicine (AFRIM) laboratories of Thailand and National Institute of Virology in Pune, India. More than 60% of the samples tested were positive for the chikungunya virus and therefore this outbreak of viral fever was attributed to the virus.

Surveillance of Cases

The following case definition was then developed for surveillance of chikungunya cases.

Case Definition

1. ***Suspected case***: A patient presenting with acute onset fever usually with chills/rigors which lasts for 3 – 5 days with multiple joint pains/swelling of extremities that may continue for weeks to months.

2. ***Probable case***: A suspected patient with above features with any one of the following:

a. history of travel or resident in areas reporting outbreaks.
b. ability to exclude Malaria, Dengue and any other known cause for fever with joint pains

3. *Confirmed case*: Any patient with any one or more of following findings irrespective of the clinical presentation.

    a. virus isolation in cell culture or animal inoculations from acute phase sera
    b. Presence of viral RNA in acute phase sera
    c. Seroconversion to virus specific antibodies in samples collected at least 1 – 3 weeks apart
    d. Presence of virus specific IgM antibodies in single serum collected after 5 days of onset of illness

All provincial and district health authorities namely provincial directors of health services, deputy provincial directors of health services and regional epidemiologists were promptly informed on the situation and guidelines were issued to initiate surveillance. A special investigation form was developed later to collect information from suspected cases, specimens of which were sent to all the sentinel sites (major hospitals) and relevant officials.

Surveillance activities on Chikungunya fever were initiated in all sentinel hospitals by regional epidemiologists by motivating the clinicians to entertain high suspicion for this illness. They were encouraged to differentiate and confirm the suspected cases from Dengue which closely resembles Chikungunya clinically. Necessary arrangements were made to transport specimens for laboratory diagnosis wherever necessary. Clinicians were persuaded to notify the confirmed as well as suspected cases by completing the special investigation forms to the Epidemiology Unit. Assistance and cooperation of the Infection Control Nurses were obtained in the institutions to carry out this task.

Prevention and Control

Medical Officers of Health were mobilized to initiate preventive measures against the spread of Chikungunya fever. This included health education campaigns for the public to highlight the mode of spread and possible preventive measures. Priority was given to organize parallel campaigns promptly to eliminate mosquito breeding places especially in public places such as schools and working places.

Information about the disease and the situation in the country was made available on the official website of the Epidemiology Unit www.epid.gov.lk. A detailed fact sheet was developed and distributed to all health institutions. This was also made available on the official website.

Electronic and print media were utilized widely to heighten public awareness on the disease and preventive measures. Feature articles and interviews in all major newspapers and periodicals, appearances and interviews on various news, current affairs and feature programmes on all television and radio channels were organized on the subject.

Affected Areas

Most affected districts were Puttalam, Kalmunai, Colombo, Jaffna, Mannar and Batticoloa, Trincomalee. Over 37000 suspected cases have been reported from the country to date. Distribution of these cases by the most affected districts is shown in Table 1 below.

Table 1. Distribution of Suspected Chikungunya Cases by Selected Districts

District	Number of Cases
Colombo	5286
Kandy	444
Matale	428
Jaffna	1512
Vavuniya	147
Batticoloa	3141
Kurunegala	327
Trincomalee	1910
Puttalam	11125
Kalmunai	4092
Mannar	9255
Total	**37667**

Source: Data from Sentinel Sites sent by regional epidemiologists

Laboratory Diagnosis

Samples from chikungunya patients from hospitals have been tested at the Medical Research Institute (MRI), Molecular Medicine Unit of the Department of Microbiology at University of Kelaniya and Gene-tech Research Institute Colombo during the outbreak period. A total of 1058 samples were tested at these laboratories and out of them 682 were positive for chikungunya.

Field Investigations

In the first week of November a team from the Epidemiology Unit visited Kalmunai, one of the worst affected districts to investigate the situation and to provide technical guidance. On their recommendations, OPD and inward surveillance of the regional hospitals was strengthened, a system was designed to investigate all fever related deaths in detail, education programmes for hospital staff organized, regular clinical reviews on case situation encouraged and a thorough mosquito control programme along with entomological surveillance was initiated to cover all affected areas in the district.

In the first week of December another team from the Epidemiology Unit visited Kalmunai again to investigate an unusual increase in fever related deaths. Following a detailed investigations it was concluded that none of these deaths were related to Chikungunya. Their recommendations included strengthening of surveillance, clinical review of case situation, detailed death investigations and developing clinical management guidelines.

Regional Epidemiologists in worst affected districts such as Puttalam and Jaffna had also visited MOH areas (Kalpitiya in Puttalam and MC Area in Jaffna) with large numbers of patients to conduct investigations and to organize control measures.

Conclusion

According to the data analyzed up to date at the Epidemiology Unit, the outbreak appears to be on the wane. However surveillance in the sentinel hospitals is being continued with support from the regional health administrators and hospital staff. Data obtained through the Regional Epidemiologists to date may be underestimated since the initial surveillance activities prior to the introduction of the special investigation forms would not have yielded accurate figures. Further these data was with regard to hospital-inward patients and those who attended out patient departments at hospitals. Therefore it excludes the large numbers who opted not to seek hospital care and were treated by the general practitioners.

Making the Right to Health a Reality: Legal Strategies for Effective Implementation

Iain Byrne[♦]

Introduction

This paper seeks to examine how non-codification of the right to health in domestic law is not necessarily a bar to both consideration and enforcement by the courts of healthcare and treatment issues through innovative approaches taken by jurists. It demonstrates some of the major challenges faced by courts – whatever the domestic legal framework – in considering health issues and the some of the strategies that can be employed to ensure effective implementation. The UN Committee on Economic, Social and Cultural Rights in its General Comment 9 has emphasised that it is up to states how they give effect to the rights contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR), including the right to health, but whatever arrangements they choose they must be effective:

> *"..[T]he central obligation in relation to the Covenant is for States parties to give effect to the rights recognized therein. By requiring Governments to do so "by all appropriate means," the Covenant adopts a broad and flexible approach which enables the particularities of the legal and administrative systems of each State, as well as other relevant considerations, to be taken into account. But this flexibility coexists with the obligation upon each State party to use all the means at its disposal to give effect to the rights recognized in the Covenant. In this respect, the fundamental requirements of international human rights law must be borne in mind. Thus the Covenant norms must be recognized in appropriate ways within the domestic legal order, appropriate means of redress, or remedies, must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place."* [Paras 1 and 2]

Given that the majority of Commonwealth states have ratified the ICESCR (with some notable exceptions such as South Africa which has its own progressive constitution – see further below) these entreaties should carry some force not the least in those countries such as the UK, Canada, Australia and New Zealand which have no constitutionally entrenched esrs. Hence the role of the courts is vital in ensuring that liberal and purposive interpretations are given to those fundamental guarantees that are codified in order to offer the prospect of indirect protection for esrs such as the right to health.

Both states and the international community have tended to pay lip service to the principle that all rights are of equal status, indivisible and interdependent, as elaborated in instruments such as the Universal Declaration of Human Rights and the Vienna Declaration and Programme of Action[1], with

---

[♦]Commonwealth Law Officer, *Interights*; Visiting Fellow, Human Rights Centre, Essex University, paper delivered at the Commonwealth Law Conference, London September 2005

[1] Article 5 of the Vienna Declaration states: 'All human rights are universal, indivisible, interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms.'

economic, social and cultural rights often regarded (at least in the developed world) as the poor cousin of their civil and political counterparts.[2] Yet it is self-evident that the right to health has clear links to many other rights, both civil and political – e.g. rights to life, not to be subjected to torture or cruel, inhuman or degrading treatment and to information – or economic and social – e.g. rights to food, environment, housing, work and education. This can be seen both in the impact the denial or enjoyment of other rights can have on a person's ability to achieve the highest attainable standard of physical and mental health[3] and, conversely, the role health plays in our enjoyment of other rights – an unhealthy citizen is not able to play a full and active part in society either economically or politically.

Traditionally, health issues when they reach the courts (particularly in those jurisdictions where there is no explicit guarantee to the right to health) have tended to be dealt with from a negative civil liberties perspective rather than consideration of the positive state obligations to provide adequate resources or access to treatment for effective enjoyment. This is particularly the case in relation to mental health where judgments have tended to focus on the restrictions placed on patients rather than their right to adequate treatment. There have been some rare forays by tribunals into examining positive aspects but often the analysis is limited.[4]

How far judges should be prepared to go in deciding questions with resource implications – something which does not just effect the right to health but clearly all economic and social rights (esrs) – is a crucial question, whether rights are codified or not. Certainly, violations of esrs are easier to identify and remedy when state obligations relate to respecting and protecting rights - the lower end of the typology framework used by the UN Economic, Social and Cultural Rights Committee and other experts – rather than at the more contentious provision or fulfilment stage.[5] Where claims are sought in relation to the latter, one leading commentator on the right to health has noted that they will be most likely to be successful where the obligations relate to clearly defined rights of access to health-related services.[6]

---

[2] This is reflected in the disproportionate amount of resources devoted to civil and political rights by the UN human rights machinery, an imbalance that has only begun to be addressed during the last decade.

[3] The formula used by Article 12 of the International Covenant on Economic, Social and Cultural Rights which states: '1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'

[4] See *Moore v Gambia* (241/2001) in which the African Commission on Human and Peoples Rights stated that the state was under an obligation to realise the right to health of mental health patients to the maximum of available resources but did not elaborate beyond this.

[5] For a fuller exposition of state obligations in relation to the right to health under the ICESCR see General Comment 14 on The Right to the Highest Attainable Standard of Health by the UN Committee on Economic, Social and Cultural Rights (E/C.12/2000/4)

[6] Brigit Toebes 'The Right to Health' in Eide, Krause and Rosas, *Economic, Social and Cultural Rights: A Textbook* (Martinus Nijhoff 2001) p184. Toebes cites a decision of the Dutch Central Appeals Court in 1996 holding that ILO Convention 102 on right to a certain medical benefit in a hospital did have direct effect and was self-executing because the services were closely circumscribed and the provisions were imperative in nature.

Codification of the right to health in domestic law – enhanced protection but still problematic

Chile provided the first constitutional recognition of the right to health as far back as 1925. Subsequent constitutional provisions have taken various forms with clauses elaborating amongst others;

(i) a right to general well-being (e.g. South Africa[7] where the guarantee is part of a provision requiring access to health care services, food and water and social security (see further below) and similarly in Finland[8]);

(ii) a right to free medical services (e.g. Guyana[9]);

(iii) a right to a healthy environment (e.g. Hungary[10])

(iv) a right to enjoy the highest possible level of physical and mental health (e.g. Hungary[11]);

(v) a direct relationship to right to the life (e.g. Haiti[12]);

(vi) specific state obligations (e.g. Netherlands[13] and Haiti[14]).

---

[7] Article 27 of the South African Constitution provides: '(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.'

[8] Section 19 of the Finnish Constitution provides: '(1) Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. (2) Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. (3) The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the well-being and personal development of the children. (4) The public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.'

[9] Article 25 of the Guyana Constitution provides: Every citizen has the right to free medical attention and also to social care in case of old age and disability.'

[10] Article 18 of the Hungarian Constitution provides: 'The Republic of Hungary recognizes and shall implement the individual's right to a healthy environment.'

[11] Article 70D of the Hungarian Constitution provides: '(1) Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health. (2) The Republic of Hungary shall implement this right through institutions of labor safety and health care, through the organization of medical care and the opportunities for regular physical activity, as well as through the protection of the urban and natural environment.'

[12] Article 19 of the Haitian Constitution provides : 'The State has the absolute obligation to guarantee the right to life, health, and respect of the human person for all citizens without distinction, in conformity with the Universal Declaration of the Rights of Man.'

[13] Article 22 of the Dutch Constitution provides: '(1) The authorities shall take steps to promote the health of the population. (2) It shall be the concern of the authorities to provide sufficient living accommodation. (3) The authorities shall promote social and cultural development and leisure activities.'

[14] Article 23 of the Haitian Constitution provides : 'The State has the obligation to ensure for all citizens in all territorial divisions appropriate means to ensure protection, maintenance and restoration of their health by establishing hospitals, health centers and dispensaries.'

(vii) Directive Principles of State Policy (DPSP) (e.g. India[15], Philippines[16], Malawi[17], Uganda[18] and Ghana[19]).

In terms of the Commonwealth, a non exhaustive survey reveals that the developed economies (e.g. UK, Australia, Canada, New Zealand) and Caribbean jurisdictions (with the exception of Guyana) do not provide for any explicit recognition of health rights whilst African and South Asian countries do (albeit often by way of DPSP although, as will be shown below, this is not a bar to judicial recognition and enforcement). This divide reflects the geo-political context of the post World War II world where Western and Western influenced states tended to favour civil and political rights over esrs whilst those states more closely allied to the Soviet bloc, or non-aligned in the case of India, and engaged in colonial independence struggles took an opposite view point. The end of the Cold War and increasing recognition, not least amongst jurists, that both sets of rights are interconnected and of equal value have provided new avenues of legal protection, particularly in the case of esrs such as the right to health. The remainder of this paper seeks to explore some of these developments and what lessons can be learned for future litigation strategies.

The South African Experience

Of those countries that do provide constitutional recognition of a right to health and other esrs, arguably one of the best known and most widely celebrated in the Commonwealth (if not beyond) is South Africa reflecting the values of the pluralist, egalitarian and democratic state that replaced apartheid in 1994. However, it should be noted that although esrs are a prominent feature of the

---

[15] Article 47 of the Indian Constitution provides : 'Duty of the State to raise the level of nutrition and the standard of living and to improve public health.- The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.'

[16] Article 13 of the Filipino Constitution provides: Social Justice and Human Rights: Section 1. The Congress shall give highest priority to the enactment of measures that protect and enhance the right of all the people to human dignity, reduce social, economic, and political inequalities, and remove cultural inequities by equitably diffusing wealth and political power for the common good. To this end, the State shall regulate the acquisition, ownership, use, and disposition of property and its increments. Section 2. The promotion of social justice shall include the commitment to create economic opportunities based on freedom of initiative and self-reliance.'

[17] Article 13(2) of the Malawian Constitution provides : 'The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals....To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.'

[18] Article 14 of the Ugandan Constitution provides: 'General Social and Economic Objectives: The State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that-(i) all developmental efforts are directed at ensuring the minimum social and cultural well-being of the people; and (ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work decent shelter, adequate clothing, food security and pension and retirement benefits.'

[19] Article 34 of the Ghana Constitution provides: (1) The Directive Principles of State Policy contained in this Chapter shall guide all citizens, Parliament, the President, the Judiciary, the Council of State, the Cabinet, political parties and other bodies and persons in applying or interpreting this Constitution or any other law and in taking and implementing any policy decisions, for the establishment of a just and free society. (2) The President shall report to Parliament at least once a year all the steps taken to ensure the realization of the policy objectives contained in this Chapter and, in particular, the realization of basic human rights, a healthy economy, the right to work, the right to good health care and the right to education.

Constitution these were not included without a struggle[20] and significant cases to date amount to no more than half a dozen. Esrs are divided into three broad categories: (a) basic rights with no qualification on implementation covering children's rights, basic education for everyone including adults and rights of detainees; (b) access rights covering the main guarantees to adequate housing, food, water, social security, and health care based on progressive realization according to available resources (a similar formulation to Article 2(1)[21] of the International Covenant on Economic, Social and Cultural Rights (ICESCR) although South Africa has yet to ratify it) and (c) prohibition on certain negative actions by the state including forced evictions and refusal of emergency medical treatment.

The specific provision protecting health rights is Article 27 which provides (as part of a general well being provision similar in formulation to Article 25 of the Universal Declaration of Human Rights and s 19 of the Finnish Constitution) that:

> *"(1) Everyone has the right to have access to*
>
> *(a) health care services, including reproductive health care;*
> *(b) sufficient food and water; and*
> *(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.*
>
> *(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.'*

Health rights, together with housing rights, have provided the most significant constitutional esrs cases considered by the South African courts to date and this paper considers three of them. In *Soobramoney v Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696 the Constitutional Court was faced with not merely one of its first esrs cases but potentially difficult moral questions to consider. S had chronic kidney failure which was terminal. However, costly dialysis treatment would have prolonged his life for a short period, but the local health authority refused it on the grounds of lack of resources. In his claim S relied on s 27(3) protecting the right to emergency medical treatment construed with the right to life as guaranteeing him a right to cost free medical treatment. Distinguishing the Indian case of *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal* 1996 AIR SC 2426[22] (see further below) the Court held there was no need to infer a right to medical treatment from the right to life since it was directly protected by s 27. However, it went on to rule that a request for ongoing treatment could not come under emergency medical care and therefore the case fell to be decided under the access to medical services provisions. On this point the Court found no

---

[20] See Pierre De Vos 'Pious Wishes or Directly Enforceable Human Rights? Social and Economic Rights in South Africa's 1996 Constitution' *South African Journal on Human Rights* Vol 13 p 67 (1997)

[21] Article 2(1) provides: 'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'

[22] By distinguishing the West Bengal case it raises the question whether faced with the Indian situation of refusal of emergency medical treatment the Constitutional Court would have restricted itself to dealing with the particular situation faced by the victim or would have attempted to lay down a policy for compliance with the constitutional principle as the Indian Supreme Court sought to do.

breach since, within the context of the limited resources available, the health authority had acted reasonably and applied its guidelines rationally and fairly in the case of S given (a) the expensive nature of the treatment and (b) the fact that it would only have prolonged S's life for a short period. For the Court this has been the crucial test in considering all esrs claims – has the State done all it could reasonably do in the circumstances?[23]

By adopting this approach the Court has recognized that it is not in a position to assume the role of the state in making decisions about resource allocation but is instead there to act as an impartial arbiter. This process is similar in format to judicial review although will often extend beyond the decision-making process to examine all the actions taken by the state. Indeed in *Soobramoney* the Court was very explicit about the large margin of discretion it would give to the state to set budgetary priorities stating that the court *"will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities"* [para 29]. Sachs J went further stating that *: "In open and democratic societies based upon dignity, freedom and equality, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care"* [para 52]. To admit S's case would have been to open the floodgates to other claimants in a similar position placing an unbearable strain on medical resources.[24]

The second significant health case considered by the Constitutional Court and one of the most widely known due to the issues involved is *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC) or the TAC case. The Court was required to determine whether the state's failure to provide comprehensive anti-retroviral drugs to prevent mother-child HIV transmission constituted a breach of Article 27(1). The state argued that the drugs could only be distributed through a few centres designated for research which were able to provide the necessary complementary services such as counselling, new obstetric practices and education of mothers in alternative to breast feeding. The Court held that whilst research was important this was not a sufficiently good reason for delay in rolling out the programme to other centres: *"This does not mean....that until the best programme has been formulated and the necessary funds and infrastructure provided for the implementation...the drug must be withheld from mothers and children who do not have access to the research and training sites. Nor can it reasonably be withheld until medical research has been completed"* [para 68].

An important factor for the Court was the fact the drug (unlike the treatment in *Soobramoney*) was costless to the government and therefore arguments centred on lack of resources did not carry any weight. However, by requiring that the programme should include reasonable measures for counselling and testing, the Court did make orders with some (albeit limited) financial implications. Beyond this and unlike the approach often taken by the Indian Supreme Court and the Inter-American Court of Human Rights, the Court refrained from discussing detailed modes of implementation. Arguably, this created subsequent problems regarding the implementation of the judgment since it took several months of campaigning and lobbying by TAC and others to force the authorities to act and start supplying the drugs. The lessons from the TAC case demonstrate that obtaining a positive judgment, particularly in relation to esrs is only half the story, and that ensuring effective implementation is often a greater challenge.

---

[23] See the landmark decision of *Government of RSA v Grootboom* 2000 (11) BCLR 1169 (CC)

[24] See also the approach of the New Zealand Court of Appeal in *Shortland v Northland Health* [1998] 1 NZLR 433 examined below.

The third case, *B & Ors v Minister of Correctional Services* [1997] ICHRL 37, considered by the High Court, also concerned the supply of anti-retroviral drugs and whether they should be provided to HIV prisoners at the state's expense. The Court, in finding a breach of a prisoner's right to adequate medical care under s 35(2) of the Constitution, held that given this guarantee is not a right provided to people outside prison, the latter should not be an absolute standard for what is adequate for prisoners. The Court recognised that unlike free persons, prisoners have no access to other resources to gain medical treatment and that HIV positive prisoners are more exposed to opportunistic viruses because of overcrowded accommodation. In these circumstances the extension of life expectancy and enhanced quality of life provided by anti-viral therapy required the treatment to be provided to sufferers of HIV if at all affordable. In particular, the Court held that where anti-viral therapy has been prescribed to a prisoner on medical grounds then it should be provided at the state's expense and failure to do so amounted to an infringement of Article 35(2).

However, the Court also continued to proscribe the limits of the judiciary's role in health cases by stating that whether the applicants and other HIV patients who fell within certain grounds were entitled to a prescription of a particular combination of anti-viral treatments was a medical question and it was not the court's function to make an order dictating to doctors when they must prescribe anti-viral treatment without discretion. Moreover, it recognised that in deciding what 'adequate medical treatment' constituted in terms of s 35(2) the court could and should be aware of budgetary constraints.

The cautious approach of the South African courts in relation to esrs contrasts with the more assertive stance of their Indian brethren who over a much longer period have frequently been willing to actively intervene in policy and administrative areas usually viewed as the preserve of the executive, handing down detailed orders often with significant resource implications (see further below) . Critics of the Indian approach have pointed to the lack of cooperation it has apparently engendered in state officials requiring, on occasion, contempt of court proceedings to be initiated. However, the TAC case illustrates that the South African Constitutional Court cannot rely on the goodwill of officials to implement its decisions and may also have to be more proactive in monitoring and enforcement whilst continuing to walk a fine line in preserving the separation of powers.

Other examples from beyond the Commonwealth

The universality of human rights law can blur the distinction between different legal systems allowing us to draw on examples not just from the common law but also from other systems, whether, for example, the civil law in Latin America or post Soviet system in Eastern Europe. This is particularly important in relation to esrs, given the relative underdevelopment of caselaw, both in terms of interpreting the content of the right and the nature of state obligations.

Three cases from Latin America deal with similar problems explored in the TAC case concerning inadequate state responses to pandemic diseases. One of the leading decisions is *Mariela Viceconte v Ministry of Health and Social Welfare* Case No 31.777/96 (1998) from Argentina in 1998.[25] The claim was brought by a number of community groups to ensure that the state would manufacture a

[25] For a further discussion of the case see Abramovich ' Argentina : The Right to Medicines' in *Litigating Economic, Social and Cultural Rights : Achievements, Challenges and Strategies* (COHRE 2003)

vaccine against Argentine hemorrhagic fever, threatening the lives of 3.5 million people, most of whom did not adequate access to preventive medical services, in certain affected areas. Whilst the state had been able to obtain 200,000 doses of a vaccine from the United States and vaccinate 140,000 people between 1991 to 1995 it was unable to carry out a massive immunisation campaign due to the lack of an adequate quantity.

A judicial writ of amparo (a constitutional remedy providing individual relief) was filed requiring the health ministry to manufacture and distribute further supplies of the vaccine to persons living in the affected areas. Following initial rejection the Court of Appeals ruled favourably establishing the state's obligation to manufacture the vaccine. Significantly (and unlike in South Africa) the court also set a legally binding deadline for the obligation to be met. In reaching its judgment the court drew on regional and international human rights standards, including the American Declaration on the Rights and Duties of Man, the UDHR, but particularly the right to health under Article 12 of ICESCR, all of the instruments having been incorporated into the domestic law in Argentina and considered to form part of the Constitution. This was in direct response to the petitioners' assertion that where a state is facing a major health problem threatening significant numbers of lives the legal obligation under Article 12 of the ICESCR is particularly strong.

As in the TAC case, it required further action by the groups, including litigation, to secure enforcement. Nevertheless, the case is seen as important for a number of reasons. It reaffirmed the judicial process as a method for enabling ordinary citizens to challenge state agencies regarding the merit of health policies, saw the direct application by a domestic court of international standards on the right to health thereby expanding the scope for further realization of esrs; imposed personal responsibility on two ministers for the manufacture of the vaccine with a specific deadline thereby demonstrating that the obligations arising from esrs are legal in nature and entail legal liabilities and affirmed the role of the state as guarantor of the right to health in the event that the private sector is unable or (more likely) unwilling to provide the necessary services. Ultimately cases such as *Mariela Viceconte* can have a political as well as legal impact far beyond that perhaps envisaged when the original petition was submitted. Within five years Argentina had developed a social plan to deliver basic medicines the roots of which can be directly traced to the *Viceconte* case.

A case concerning HIV is *Mendoza & Ors v Ministry of Public Health* Resn No 0749-2003-RA (28 Jan 2004) from Ecuador where the Constitutional Court held that Ministry of Health had failed in its obligation under Article 42 of the Constitution to protect the right to health by suspending a HIV treatment programme. Again, in upholding the right to health, references were made to relevant international standards including Article 11 of the American Declaration on the Rights and Duties of Man and Article 10 of the San Salvador Protocol. The Court also held that although right to health is an autonomous right it also forms part of the right to life echoing the approach of the Indian Supreme Court (see the *West Bengal* case below). In so doing it envisaged that a right to health entitled citizens not only to take legal action for the adoption of policies and plans related to general health protection but also to demand that appropriate laws be enacted and that the Government provide the necessary resources. Whilst such a judgment might be seen as having enormous implications for the executive it provides the measure of accountability necessary to achieve effective implementation of the right to health.

In Central and Eastern Europe the legacy of the Soviet system where priority was given to economic and social rights over civil and political freedoms has not only resulted in a number of constitutions expressly recognising the right to health, but also Constitutional Courts adopting a more collective approach, e.g. in both Hungary and Poland the courts have interpreted right to health (or free health care) as non-individual rights satisfied by the provision of public services by the state. The Hungarian Constitutional Court has been particularly vigorous, adopting a 'ratchet' approach which recognises a state duty to maintain the level of services (e.g. welfare benefits, number of patient beds) even during economic austerity. The result is that once a certain level of protection is provided under statute it cannot be repealed or diminished by a subsequent law.[26] Compare this approach to the UK where economic and social rights have tended to be subject to the vagaries of the government of the day unless the courts are prepared to indirectly protect healthcare rights through innovative application of the European Convention on Human Rights standards (see further below). The Hungarian approach is more in line with the 'progressive realisation' of the ICESCR, although this was not explicitly mentioned by the Constitutional Court which based its argument instead on the principle of legal certainty which respected vested rights and recognised legitimate expectations.[27]

Non-codification – the need to adopt innovate approaches

The lack of express constitutional protection for health rights provides courts, lawyers and activist with significant but not insurmountable challenges for enforcement. Much will depend upon how far courts will be prepared to go in offering creative but legitimate approaches which do not exceed the scope of judicial powers.

Techniques include: (a) adopting expansive definitions of civil rights some of which tend to be widely if not universally guaranteed under domestic law, e.g. rights to life or not be subjected to cruel, inhuman or degrading treatment. This approach has been sanctioned to differing degrees by both the UN Human Rights Committee and the European Court of Human Rights.[28] The former in its General Comment Number 6 para 5 on the right to life stated:

> *"the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics."*

Indeed, as the previous comment makes clear that the Committee was explicitly considering health issues in adopting a more liberal interpretation of the right to life; (b) considering the due process issues by exercising some form of judicial review. This has tended to be the approach adopted by the

---

[26] Some have criticised this approach as being too interventionist but there is no evidence that the Court's judgments hindered the transition of Hungary to a more mixed economy during the 1990s. See Schepele 'A Realpolitik Defense of Social Rights' 82 Tex Law Review 1921 (2004)

[27] In this respect the Hungarian Court adopts a similar approach to the European Court of Justice.

[28] In the case of *Osman v UK* (2000) 29 EHRR 245 the Court recognised the positive obligations on the state to protect the right to life (in this case the police in relation to threats to the victim made by another individual) leading some to conclude that this could be extended to economic and social rights although this has yet to be tested.

British courts in the absence of any express constitutional protection but suffers from the fact that only the reasonableness of the decision-making process itself is considered rather than the substance of the right although it may still allow for some indirect protection of esrs (c) use of cross-cutting provisions such as equality and non-discrimination which, again, may not allow for consideration of the substantial economic or social right but at least afford some measure of indirect protection.

The Indian story: activism and innovation

Although South Africa has tended to attract much of the attention amongst Commonwealth jurisdictions for its protection of economic and social rights Indian courts have been at the forefront of esrs litigation for over three decades. The Indian Constitution, promulgated in 1947, is a creature of its age and on its face far less progressive than its South African counterpart from the mid 1990s. Economic and social rights, including the right to health contained in Article 47[29] (as in a number of other Constitutions such as the Philippines, Ghana and Uganda) are consigned to the Directive Principles of State Policy (DPSP) section. According to Article 37 of the Constitution DPSP *"shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws."*

Therefore on its face the Supreme Court is barred from considering and enforcing individual health rights claims but rather is concerned with offering non-binding guidelines on how health policies should be implemented whilst leaving the final decision to the state. However, the early 1970s witnessed a watershed in Indian human rights litigation with the *Fundamental Rights Case*[30] ushering in an unprecedented period of progressive jurisprudence following the recognition by the Court that DPSP should enjoy the same status as 'traditional' fundamental rights. At the same time standing rules were relaxed in order to promote public interest litigation and access to justice. Suddenly writ petitions could be submitted on a postcard.[31]

The main means by which the Supreme Court has achieved equivalence between civil rights and their economic and social counterparts has been through the application of an expansive definition of the right to life. Unsurprisingly the right to health was one of the guarantees to first benefit from this approach.[32] To date one of the most significant right to health decisions has been the public interest litigation case of *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37 where the Supreme Court used the right to life to secure the right to emergency medical care concluding that such an essential obligation could not be avoided by pleading financial constraints. The petitioner had been taken to a succession of eight state medical institutions ranging from a local health centre to two medical colleges and was refused treatment at each either due to lack of beds or lack of technical capacity. Eventually he was admitted to a private hospital where he was treated at a cost of Rs. 17,000. The Court, in holding that there had been a violation of the right to life under Article 21 and

---

[29] *Supra* n.15

[30] *Keshavananda Bharati v. State of Kerala* (1973) 4 SCC 225

[31] For a good overview of the Indian courts' approach to esrs see S. Muralidhar 'Justiciability of Economic and Social Rights – The Indian Experience' in *Circle of Rights* (IHRP 2000)

[32] See *Francis Coralie Mullin v. The Administrator, Union Territory of Delhi* (1981) 2 SCR 516 concerning detention conditions and *Parmanand Katara v. Union of India* (1989) 4 SCC 286 regarding obligation of state to provide emergency medical treatment.

awarding compensation, stated that the right to emergency medical care formed a core component of the right to health which in turn was recognised as forming an integral part of the right to life. It did this by reconceptualizing the right to life as imposing a positive obligation on the state to safeguard the life of every person stating that *"preservation of human life was of utmost importance"* and that:

> *"The Constitution envisages the establishment of a welfare state...Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in this respect and discharges this obligation by running hospitals and health centres."*

In line with its general approach of frequently offering comprehensive remedies that go beyond merely providing redress for the victim but also lay down the necessary policy and administrative steps to be taken by the state in the wider public interest, the Court not only ordered compensation, but also directed the type of facilities that the state government had to provide. This included hospitals and emergency provision (ambulances and communications) by formulating a blueprint for primary health care with particular reference to treatment of patients under an emergency as part of the state's public health obligation under Article 47. Furthermore, the Court ruled that its orders should apply to other states, together with the national government, and that they should be sent a copy of the judgment.

However, in *Consumer Education and Research Centre v. Union of India* (1995) 3 SCC 42 the Court recognised that state resources are not limited and that no breach of the Constitution was incurred by reducing some employees' entitlements to medical benefits:

> *"No State or country can have unlimited resources to spend on any of its projects. That is why it only approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provision on facilities cannot be unlimited. It has to be to the extent finances permit. If no scale or rate is fixed then in case private clinics or hospitals increase their rate to exorbitant scales, the State would be bound to reimburse the same. "*

During the last two decades the Court has considered many public interest litigation cases involving protection of the environment, many of them brought by lawyer and activist, M C Mehta. These cases not only demonstrate the links between environmental rights and rights to health and to life, but also demonstrate how active the Supreme Court is prepared to be on occasion to secure protection of esrs. In *Mehta v Union of India* (1999) 6 SCC 9 the Supreme Court, after appointing an expert committee to formulate a detailed policy on conversion from petrol to cleaner fuels for vehicles in heavily polluted Delhi and incorporating its recommendations, issued several time-bound directions for conversion. However, the Court had to contend with the charge that these orders were inconsistent with existing statutes and that it was illegitimately extending its jurisdiction into an area of competence normally reserved for the executive. The Court responded that the directions were necessary to safeguard people's right to health and therefore should trump statutory provisions. Hence in exercising its mandate as the guardian of constitutional rights, the Court made clear that the public health considerations were clearly significant enough to justify taking a major policy decision rather than a stricter adherence to separation of powers.

This activist approach has had an impact beyond India's own borders to other countries in the South Asian region who have also framed esrs under DPSP. In *Dr Mohiuddin Farooque v Bangladesh & Ors (No 1)* 48 DLR (1996) HCD 438 the Bangladeshi Supreme Court, upon finding that a consignment of powdered milk imported by a company exhibited a radiation level above the acceptable limit in some (but not all) of the examinations conducted by various government testing bodies, upheld the claim that the actions of government officers in not compelling the importer to send the consignment back to the exporter had violated the constitutional right to life of people who were potential consumers. The Court noted that the right to life is not limited to the protection of life and limb necessary for the full enjoyment of life but also includes, amongst other things, the protection of the health and normal longevity of an ordinary human being and that if this was threatened by a man made hazard then the state could be compelled by the court to remove the threat (unless justified by law) even where its primary DPSP obligation under Art 18 to raise the level of nutrition and improve public health could not be enforced. Hence, as in the Indian cases, the Court was recognizing that artificial divisions between 'Fundamental Rights' and DPSP provisions should not prevent it acting to safeguard public health.

Creative approaches from other Commonwealth jurisdictions

Canada has no express provision protecting the right to health in its Charter of Rights and Fundamental Freedoms. Yet this has not prevented the Supreme Court from indirectly offering protection to the right by using other provisions. In particular, the equality provision under Article 15 has been used to protect esrs on the basis that similar treatment may not always guarantee substantive equality in order in the words of former Supreme Court Justice L'Heureux Dube to achieve a *"contextual and empathetic approach to ensuring each person's human dignity"*.[33] In this context the Court has ruled that whilst s 15 does not impose upon governments the obligation to take positive actions to remedy the symptoms of systematic inequality, it does require that the government should not be a further source of inequality.

The main health care case to date is *Eldridge v British Columbia* [1997] 3 SCR 624 which involved deaf individuals challenging the failure of a provincial government to provide sign-language interpreters as part of its publicly funded healthcare system. The Court held that this constituted discrimination on the basis that government should ensure that in providing general benefits to the population they should guarantee that disadvantaged members of society have the resources to take full advantage of these benefits and, in this context, effective communication was an indispensable component of the delivery of medical services. To hold otherwise was, for the Supreme Court, a *"thin and impoverished view... of equality"* [para 73]

New Zealand has a very limited Bill of Rights centred on the protection of basic civil liberties. However, in the case of *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 this did not prevent the Court of Appeal, through a generous interpretation of the right to life as protected by Article 8 of the Bill of Rights, and drawing on the equivalent international provision - Article 6 of the International Covenant on Civil and Political Rights (ICCPR) - from assessing a clinical decision to withdraw

[33] See for example decisions such as *Corbiere v Canada* [1999] 2 SCR 203 and *M v H* [1999] 2 SCR 203. This approach has been criticised by the leading Canadian constitutional commentator Peter Hogg as ' vague, confusing and burdensome to claimants' Hogg *Constitutional Law of Canada* (Student Edition Carswell 2002) p 1059

dialysis treatment according to human rights principles. In so doing the Court recognized that s 151 of the Crimes Act 1961 placed a legal duty on the local health authority to supply the patient with 'the necessaries of life' and that a failure to perform that duty 'without lawful excuse' could lead to criminal responsibility. The Court noted that this positive duty was related to the right to life as guaranteed by Article 6(1) of the ICCPR and the understanding of that provision as elaborated by the United Nations Human Rights Committee in its General Comment 6.

The Court held that extent of the duty to provide the necessaries of life must be assessed in the context of the intensive appraisal of the patient's condition by the clinical team which had knowledge of his condition and his ability to benefit from dialysis. In so doing it recognized that judges were concerned with the lawfulness of the decision to discontinue dialysis and not with the likelihood of the effectiveness of the treatment.[34] Hence, the Court found that, in light of the careful assessment of the patient by the clinical team, who had come to a *bona fide* decision that the cessation of treatment was in his best interests, Northland Health could not be said to be in breach of its duty to provide the necessaries if life and that therefore the decision to withdraw dialysis was not objectionable and would not deprive the patient of his right to life.

The Court of Appeal's approach clearly mirrors that of the South African Constitutional Court in *Soobramoney* (see above) with judges recognizing that in right to health issues there are clear boundaries which they should not cross. Their main task is to assess whether those responsible for providing treatment had done all they could reasonably could do in the circumstances either in terms of making clinical decisions or how to manage limited resources.

The UK courts, in the absence of the right to health or any esr guarantees incorporated into our domestic law, have again needed to adopt a creative approach using the limited set of fundamental civil guarantees contained in the European Convention on Human Rights that have been incorporated through the Human Rights Act 1998, in particular those safeguarding against cruel and inhuman treatment and respecting family life. However, it is important to recognise that in the UK, as in other jurisdictions where health rights are not entrenched, this is still very much an emerging area of law and that the record is mixed at best, as illustrated by a number of recent cases.

In *Watts, R (on the application of) v Bedford Primary Care Trust & Ors* [2003] EWHC 2228 the High Court considered the extent of the state's positive obligations to provide healthcare regarding a claim for reimbursement of costs following treatment abroad. The applicant relied on both Articles 3 and 8 of the ECHR. The Court recognized the wide reach of both provisions and that *"the Strasbourg jurisprudence demonstrates that Articles 3 and 8 do not only impose on the State merely negative obligations not to act in such a way as to interfere with the rights protected by those Articles. They also in certain circumstances impose positive obligations to take measures designed to ensure that those rights are effectively protected."* [para 45]. However, Munby J went on to hold that in the light of the Court of Appeal decision *R v North West Lancashire Health Authority ex p A* [2000] 1 WLR 977, Article 8 imposes no positive obligations to provide medical treatment and that the pain and suffering endured by the applicant in not receiving treatment was not sufficiently serious to engage Article 3. Although the applicant was not able to succeed using human rights law he was able to on

[34] The Court applied the English Court of Appeal decision *R v Cambridge Health Authority; ex parte B* [1995] 1 WLR 898 at 905

the basis of European Community law. Nevertheless, it appears unlikely until *R v North West Lancashire Health Authority ex p A* is overruled that claims for meeting medical treatment costs based solely on human rights arguments will succeed.

However, this does not mean that positive healthcare issues cannot engage the Human Rights Act. In *Goldsmith, R (on the application of) v London Borough of Wandsworth* [2004] EWCA Civ 1170 the Court of Appeal addressed the failure of a local authority to sufficiently consider a patient's right to private life under Article 8 of the ECHR when deciding to transfer her to a nursing home. The Court concluded *inter alia* that the decision-making process had not acted in the best interests of patient in securing her health, together with a complete failure to take into account her Article 8 rights, thereby recognizing that a patient's right to respect for her private life does not cease upon her entering a healthcare institution.

A number of recent decisions could have a significant impact – both positive and negative – on the health of asylum seekers, a particularly vulnerable segment of the British population. On the positive side the courts have recognised that asylum seekers should not be thrown into destitution by denying them access to welfare benefits. This was affirmed by the Court of Appeal in *Secretary of State for the Home Department v Limbuela & Ors*[35] [2004] EWCA Civ 540 when it held that the state has a duty under Article 3 of the ECHR to prevent homeless asylum-seekers from suffering destitution even where they had failed to make an asylum claim as soon as reasonably practicable under s 55(1) of the Nationality, Immigration and Asylum Act. Applying *R (Q) v Secretary of State for the Home Department* [2004] QB 36 the Court held it was not necessary for the claimant to show the actual onset of severe illness or suffering for a claim to be established. If the evidence established clearly that charitable support in practice was not available, and that he had no other means of fending for himself the presumption would be that severe suffering would imminently follow. The majority of the Court recognised that the correct approach was one of prevention rather than 'wait and see' which could result in the victim having to endure unnecessary suffering before upholding a claim. An appeal was heard by the House of Lords in October 2004 and at the time of writing a judgment is yet to be handed down. The consequences of the decision being overturned for the health of many asylum seekers would be dire.

Limbuela, involving as it did the positive obligation of the state to provide basic sustenance for the individual, irrespective of status, in order to prevent them suffering cruel and inhuman treatment did not require recourse to arguments based on the right to health or any other relevant economic and social rights guarantees, such as right to housing. However, two other recent decisions illustrate the dangers for claimants of not being able to argue esrs which have either been incorporated into domestic law[36] or constitutionally entrenched. Both cases concerned the right of access of failed asylum seekers to medical treatment in the UK. In *Dbeis and Ors v Secretary of State for the Home Department* [2005] EWCA Civ 584 the Court of Appeal ruled that it was reasonable to return a failed asylum seeker and her son suffering from cerebral palsy to her country of origin where there were adequate medical and education facilities. The applicant had to argue her claim under Article 8 of the ECHR, but in the absence of any express entitlements to healthcare the Court ruled that the case did

[35] Two other cases were joined in the hearing: *R v Secretary of State for the Home Department ex p Tesema* and *R v Secretary of State for the Home Department ex p Adam (FC)*.

[36] Although the UK has ratified the ICESCR, together with all of the other major UN human rights treaties, it has yet to incorporate any of them into domestic law

not satisfy the exceptional test laid down in a previous case[37] and that therefore both her and her son could be deported back to the Lebanon. The case affirms a high threshold for those seeking to argue that health or other social needs should act as a bar to deportation.

An even more disturbing decision was made by the House of Lords in *N v Secretary of State for the Home Department* [2005] UKHL31 when it found that that the UK had not breached Article 3 of the ECHR by deporting a failed asylum seeker with terminal HIV/AIDS back to her country of origin despite the fact that Uganda's medical facilities were clearly significantly less advanced than the UK. The Court distinguished *D v UK* (1997) 24 EHRR 423, the European Court of Human Rights decision relied on by the appellant, on the grounds that the situation in the receiving state were not as extreme as that faced by a terminally ill patient in that case where there was no prospect of any medical care or family support. For their Lordships a claim would only succeed where *"the applicant's medical condition has reached such a critical state, that there are compelling humanitarian grounds for not removing him or her to a place which lacks the medical and social services which he or she would need to prevent acute suffering."* [para 94]. Therefore Article 3 did not require contracting states to undertake the obligation of providing aliens with indefinite medical treatment lacking in their home countries. To hold otherwise they maintained would be to open the floodgates to a myriad of claims placing an unreasonable burden on the state.

Whilst expressing sympathy for the appellant's plight and reminding the Home Secretary that he was not bound to deport her but could exercise his discretion, their Lordships concluded that she should not be allowed *" to remain in the host state to enjoy decades of healthy life at the expense of [the] state"* [para 92]. Yet their Lordships admitted themselves that without the necessary medication she had been receiving in the UK the appellant's life expectancy could be two years at best and the chances of receiving such treatment in Uganda was problematic.

One is left with the conclusion that if N could not qualify for Article 3 protection then who will in the future? It is clear that the House of Lords, as they themselves recognised, faced difficult moral choices in the case. Yet, whilst acknowledging that a line must be drawn somewhere to prevent the state (even one as wealthy as the UK) becoming overburdened, it is submitted that the scope of the protection offered to desperately ill people in the wake of *N v Secretary of State for the Home Department* is too narrow. It is also worth considering how the decision might have differed if N could have argued that she had a right to receive treatment as part of an explicit right to health under domestic law and that, given her serious condition, it was unreasonable to deport her. This is not a *Soobramoney* case where the patient, whatever the nature of the treatment she received, would only have a short period to live.

A recent decision from the Australian Federal Court of Appeal, albeit one without the resource considerations of the House of Lords case, offers a more positive example of how the situation in other countries can and should be taken into account as part of the state's decision making process. The Court in *De Bruyn v Minister of Justice and Customs* [2004] FCAFC 334 was required to consider whether it would be unjust, oppressive or incompatible with humanitarian considerations to extradite a detainee to South Africa due to the risk of his contracting HIV/AIDS in prison. The Court, in holding that the prison conditions in the requesting country must be taken into consideration, ruled that the Minister had failed to address the question whether, in the circumstances of the case, it would

[37] See *R (Razgar) v Secretary of State for the Home Department* [2004] 3 WLR 58.

be oppressive or incompatible with humanitarian considerations to surrender the subject to a country when there was a risk of contracting HIV/AIDS considerably greater than if he was not surrendered.

Conclusions

This limited survey of right to health jurisprudence from across the Commonwealth and beyond has demonstrated that express codification is not a bar to consideration of health issues by other courts. However, it will often require a creative approach and generous interpretation of existing guarantees by both lawyers and judges in order to give true meaning to the principle of indivisibility and interdependence of rights. Courts, whether assessing constitutionally entrenched rights, incorporated guarantees or conducting a more limited form of review, will need to be mindful of how far they can go in determining claims with often significant resource and policy implications as well as difficult moral choices. They will naturally be reluctant to supplant clinical decisions by health professionals but may be prepared to intervene if the state is considered to have acted unreasonably in denying services or medication to patients. Even where positive judgments are handed down the challenge of enforcement frequently remains, requiring both an active judiciary and committed health rights activists. Above all, reference to comparative and international law from a range of jurisdictions and fora should contribute to a greater understanding and appreciation of the right to health and other economic and social rights and, ultimately, to improved protection.

People's Charter for Health

By the People's Health Movement (PHM)

Introduction

In 1978, at the Alma-Ata Conference, ministers from 134 member countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of third world populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterized by growing inequalities within and between countries .New threats to health are continually emerging. This is compounded by negative forces of globalization which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata has significantly aggravated the global health crisis.

Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of health for all to its rightful place on the development agenda. Genuine, people-centered initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organizations and civil society movements, NGOs and women's groups deciples to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organized the "People's Health Assembly" which took place form 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthasthaya Kendra or GK (peoples Health Centre).

1453 participants form 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The plenary sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health Care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organization. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organizations and decided to fight together so that health

and equitable development become top priorities in the policy makers agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The charter from now on will be the common tool of a worldwide citizens' movement committed to make the Alma-Ata dream reality.

We encourage and invite everyone who shares our concerns and aims to join us by endorsing the charter.

Preamble

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed. This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

Vision

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision.

The Health Crisis

> *"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."*
> *(A voice from Central America)*

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximize their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

Principles of the People's Charter for Health

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A Call for Action

To combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

Health as a Human Right

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

Tackling the Broader Determinants of Health

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well□being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations. Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.

- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognize environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have farreaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of

natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.

- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people□based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A People-Centered Health Sector

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drugs policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.

- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

People's Participation for a Healthy World

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre-and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a People's Charter for Health. The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000. The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health moment can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the People's Charter for Health.

Amendment

- After the endorsement of the PCH on December 8, 2000, it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.
- The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

From a Peoples' Health Assembly to a Peoples' Health Movement ..... ♦

Introduction

A global People's Health Movement (PHM) began to emerge in December 2000, when nearly 1500 people from over 90 countries met for five days in Savar, Bangladesh to re-establish health and equitable development as top priorities in local, national and international policy-making. In the intervening four years from this initial People's Health Assembly (PHA), the movement has stumbled, struggled, and become stronger, and today is having an increasing impact on health policy and practice.

An indicator of the impact that PHM is now having comes from its interaction with the World Health Organisation. In December 2000, despite being invited at the highest level to attend the PHA, no one was officially representing the WHO. In January 2004, several representatives from the WHO attended the PHM activities around the World Social Forum in Mumbai, India and were requested by the Director-General's Office to explore closer engagement with the PHM.

Strong and ongoing activities have been taking place in Asia (particularly South Asia) and in Latin America. Within South-East Asia and the Pacific and the Middle East, events connected to the 25th anniversary of the Alma Ata declaration on Primary Health Care were used during 2003 to help mobilise further action. Communication processes within the movement are improving related network functioning and governance. More attention is now being paid to building and developing strong and effective alliances and working relationships with other networks, movements and organisations, as well as to engage in an strategic thinking planning exercise, including the development of a communication strategy.

The People's Charter for Health, elaborated through a worldwide consultative process and finalised and endorsed at the PHA, has been spontaneously translated into more than 40 local languages. This indicates the degree to which the Charter and its demands for social, political and economic change to improve health reflect and resonate with the reality of the situation facing the millions of people living in poverty.

PHA: A unique approach to social mobilization

A key feature of the People's Health Assembly (PHA) is that there was no real model for this type of exercise. There are many examples of international meetings, but few that feature a focus on people's voices or that start from local experience.

This People's Health Assembly – the first of its kind – was a unique social mobilisation exercise. In country after country, it involved people in village meetings, in district meetings, in national events, in regional workshops to prepare for the global gathering in Bangladesh.

♦Excerpted from 'Challenging Injustice: Giving Voice to People's Right to Health', by Andrew Chetley and Cecilia Muxi, People's Health Movement, November 2004.

Along the way, the voices of the people were heard:

- articulating their demands for better health, justice, peace and equity
- reaffirming their rights and responsibilities to be involved in the decisions that affect their lives and their health
- confirming that the right to health is one of the basic human rights to which they are entitled.

The five-day meeting in Bangladesh provided an opportunity for people involved in health, development, human rights, agriculture, trade and economics, the environment and many other fields to converge, to share ideas and continue a process of building a coalition to drive change. Anyone who took part in the PHA describes it as a transformational process. It changed their lives. The challenge now is to see if the inspiration, solidarity and linkages that occurred can be sustained.
A significant outcome of the process is that it has begun to elaborate new models for organising, new approaches to giving voice to the vulnerable and new ways to advocate for social change.

Anger at injustice

A young village health worker from Nepal enacted for everyone the plight of a young woman who was typical of many she worked with in villages. She was in bonded labour, had no food, no money. Her husband had died. Now, in order to feed her child, she would have to offer her into bonded labour. How could she put her daughter through the misery that she had faced all her life? Her final, impassioned cry was 'God help me or let me die.'

Thelma Narayan from India responded to this by adding that the story reflected the situation of millions of women in Asia and highlighted the gender inequality of poverty and ill health. 'It is the suffering that moves us,' she said.

> *'Our anger at the injustice has led us to develop strategies to cope. What we are recognising is that this is a global phenomenon and therefore the response needs to be global. We need to address the issue of power and to look at how power affects the lives of people. It is our role to influence those who hold power.'*

Planned achievements

The PHA process aimed to develop and endorse a People's Charter for Health and to achieve a further seven outputs:

- hearing the unheard
- re-enforcing the principle of health as a broad cross-cutting issue
- sharing and enhancing knowledge, skills, motivation and advocacy for change
- improving communication between concerned groups and institutions
- developing enhanced cooperation between concerned actors in the field
- enhancing media interest in health/equity issues
- increasing involvement of the poor in the dialogue process.

PHA participants surveyed feel strongly that the unheard did have an opportunity to be heard; that health was reinforced as a cross cutting issue and that skills and knowledge were shared during the Assembly itself. There was a less strong sense that communication between different groups and opportunities for enhanced cooperation happened. There was some uncertainty as to whether media interest was enhanced or to what degree the poor were really involved. Those are not surprising findings: communication processes, sustained interest and participation and involvement are all characteristics that require time and sustained interaction. In many ways, these are the challenges the newly developing movement is facing.

> *The Assembly provided an opportunity for all of us to listen to those voices and to become one with their struggles. The declaration of the Charter will be but one step in making these voices heard by policy makers, governments and international organisations.*
>
> Dr Qasem Chowdhury, Gonoshashaya Kendra, Bangladesh

A transforming experience

On balance, the overall impression of the Assembly itself from participants was that it was a unique, transforming experience. It had a profound impact on the 1500 people who attended, and nearly all of them have communicated with others about the experience in some way.

As a judge from India who attended said, 'The biggest achievement was making the world aware that the health of the common folk had to be a matter of international concern'.

The process that was set in motion to develop the PHA and get the event held was a positive one. It involved a number of organisations and networks, consulted widely on content issues, and reached out to a large audience to encourage involvement and participation. However, there were also difficulties: not least the overwhelming burn out and exhaustion of some of the organisers who faced severe stress in trying to cope with growing and unexpected numbers of participants. The sheer volume of people who attended meant that some of the carefully planned mechanisms to deal with debate and arrive at clear positions on many issues were not able to function. The issues were certainly raised and the problems articulated; clear expressions of possible solutions were not always reached. Many of the people involved in organising the event are highly critical of the outcomes.

A major failing of the process was the lack of a plan (and the resources – human and financial - to carry it out) about how to follow up the Assembly and maintain the enthusiasm and solidarity that was expressed. As a result, some of the dynamism of a new popular movement was initially lost. It was nearly a year after the PHA that the ideas for evolving a People's Health Movement that built on the first Assembly and began to work towards implementation of the demands in the People's Charter really began to develop. In that sense, the words of a professor of medicine based in the UK have some relevance: 'It was a remarkable and memorable achievement, but now what?'. Those words are echoed by a representative from a civil society organisation in India who said, 'The idea was good. The implementation could have been better.'

Taking the PHM forward

Up until the beginning of 2003, any assessment of the efforts to move the PHM forward would have had little to say that was positive. Although much work was going on behind the scenes, little was visible on the ground, and where it was, it appeared patchy, sporadic and largely uncoordinated through 2001 and 2002. Through 2003 and into 2004, greater coherence is beginning to emerge.

A large factor in the slow follow up to the PHA lay in the lack of a clear strategic plan and a corresponding communication strategy to reach out to different audiences. More recently, planning processes have come into effect that are addressing this and beginning to develop strategic approaches and concentrate on improving internal and external communication.
Other issues that the PHM needs to address include:

- maintaining and growing the movement (including the dynamics of networking)
- leadership and governance
- strategic thinking and planning (including communication and evaluation strategies).

Networking, linkages and alliances

There are enormous challenges in trying to maintain an effective network that combines a broad range of organisations and individuals. Networks, organisations, and individuals involved in the PHM work on a wide range of issues – from the very specific to the very broad – and at a number of levels – local, national, regional and international.

Related to this is the issue of linkages to other networks, movements and organisations that are working on issues that impact on health. Enhanced cooperation is important so that the PHM is visibly seen as a pro-active, inclusive and welcoming movement and is a platform that enables people to participate, without them having to convert to a particular belief, ideology or approach.

The synergy and interaction between the PHM and the International People's Health Council (IPHC) – one of the original eight groups involved in developing the PHA – is an example of this.

An area where the PHM has underperformed – although there are signs of improvement – is in generating media interest and helping to shape the external environment so that dialogue on public health issues is more of a reality. This is not an easy area of work and forging stronger and more effective alliances with networks of media personnel and those that work with media is likely to be a useful strategy to pursue.

Leadership and governance

Although there has been some discussion of possible structures (a series of interacting 'circles' or associations of people and organisations working on particular topics) to provide guidance and leadership for the PHM, there are still many unresolved issues. This is to be expected in what is a 'young movement'. However, an encouraging comment that emerged in the evaluation process is that it is a young movement 'with wisdom'.

Strategic thinking and planning

The dynamics of movements and many networks are that they often respond to situations as they arise: a policy has been issued that needs to be challenged; a threat to the environment has become evident; a human right has been violated. Something needs to be done now, with urgency. People need to be mobilised to take action. However, all of this needs to be put into the context of a strategic framework which is light and flexible while providing a unifying planning guide.

Lessons learned

During the period from the end of the PHA to the present time, many lessons have been learned and increasingly are being put into practice to improve the work of the PHM. These include:

- the need for more coordinated communication and information sharing – internally and externally. Externally, there is a greater visibility of the PHM in some arenas and fora. More could be done, but the signs are encouraging
- the importance of review and reflection processes to stimulate analysis of the work, rather than simply undertake activities – this is increasingly being incorporated into PHM steering group sessions and is enabling a more strategic vision to emerge
- allowing more time for planning and coordination of strategy – in 2003, there was a strong urge to have a second PHA sometime in 2004. It soon became evident that there was insufficient planning time for such an event and it has been put back to 2005. This has also allowed for a recognition that although there was no model for the 2000 PHA - now there is a model, imperfect and in need of improvement, but the planning time is now available to make those improvements
- better documentation of activities – which relates to internal and external communication. Internally, there is now much better documentation. This still needs to be better translated for external audiences to make more use of the communication channels that PHM has available, but it is an essential first step
- more clarity and transparency on how activities are funded, how funds are being shared and made to work more effectively in combination and with complementarity
- the importance of prioritizing and selecting key areas for action – the Charter has a wealth of action points. Any meeting or workshop is capable of generating long shopping lists of things that need to be done. Selecting a few of these that can be done is a skill that enables action to be effective. This is something that the PHM needs to continue to develop and practice to enable it to maximise its impact.

Conclusions

There were seven outputs identified in the original project proposal for the PHA. These outputs have been assessed in terms of pre-Assembly, the PHM itself, and the PHA follow up. Certainly, if we had had this exercise done 18 months earlier, it would have portrayed a more negative picture in terms of the post-PHA follow up.

This underlines the point that the development of the PHM is a social process, one that it is difficult to accelerate. It takes time to build trust, relationships, working practices and principles.

It is important that there is a continual reflection process within the PHM to focus not simply on the results, but on the way those results were achieved.

People's voices

An area that is more difficult to assess is the degree to which the voices of the unheard are more evident, including in the planning, leadership and governance of the movement. For the realities of vulnerable people to have impact on policy debates and to lead the demands for social change, considerable work needs to go into strategic positioning of the stories and the messages they contain. Support for the people whose voices are being raised needs to be strong. Their capacity to express themselves in ways that will impact policy audiences needs to be developed. And they need to be engaged in the analytical process that helps to draw out meaning from their experience, which helps them, in the words of Saul Allinsky, to digest that experience.

Their satisfaction with the results of any policy dialogues needs to be continually assessed. This is one of the biggest challenges facing the PHM.

From lessons learned to strategic thinking, planning and action

Is the PHM an appropriate platform for facilitating the voices of the unheard to be heard? In 2004, indicators show moves in the right direction:

- There has been some enhanced co-operation. Links that are evolving with key stakeholders have visible positive trends.
- Enabling dialogue and discussion in a number of forums is increasing, but there is scope for more.
- Communication strategies and practices – both internal and external – are improving. The Secretariat is demonstrating leadership, and the response of many participants in the movement to share information is becoming more evident.

Diversity

One of the exercises that the evaluation team did with nearly 80 people in 2003 in Geneva was to encourage them to identify how they came into contact with the PHM and how they pictured their involvement. The routes, the pathways, the doors through which they entered were diverse and spread over time.
The images of the movement that they drew were also diverse, but had some common elements. The ideas of joining hands, connecting and working together and of waves of energy, surging and growing were two powerful currents. Above all, the pictures they drew were a celebration of diversity and it is that diversity that is the main strength of the PHM. Sustaining and maintaining a diverse, flexible and effective movement that serves as a platform for social change is the challenge that now faces the PHM.

What does the movement or network hope to achieve in three years? In five years? In 25 years? What is the direction in which the movement is moving? What are the ways it might get there, and how will it know that it is making some progress? These are questions that need to be embedded in the strategic thinking and planning of any effective movement or network.

Subscriptions

The annual subscription rates of the LST Review are as follows:

Local:	Rs. 1250 (inclusive of postage)	
Overseas:	South Asia/Middle East	US$ 36
	S.E.Asia/Far East/Australia	US$ 41
	Europe/Africa	US$ 46
	America/Canada/Pacific Countries	US$ 51

Individual copies at Rs.150/- may be obtained from the Trust, No. 03 Kynsey Terrace, Colombo-08, and BASL Bookshop at No.153, Mihindu Mawatha, Colombo-12.

For further details, please contact;

Law & Society Trust
No. 3, Kynsey Terrace
Colombo-08
Tel: 2691228 / 2684845
Fax: 94 11 2686843