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The United Nations Convention on the Rights of Persons with Disabilities and the right to health (Article 25)

Human Rights in Health Care: How can we develop and successfully implement human rights frameworks for health and medical programmes?
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The Right to Health

The right to the enjoyment of the highest attainable standard of physical and mental health is enshrined in many human rights treaties (Schierenbeck et al., 2013). The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) specifically expresses the right to health for persons with disabilities. People with Disabilities are the largest minority group in the world, with an estimated 650,000,000 persons living with disabilities (UNCRPD, 2006). The UNCRPD was adopted by the United Nations General Assembly on 13th December 2006 and is a legally binding international human rights convention that restates existing human rights in light of the needs of persons with disabilities (UNCRPD, 2006). The UNCRPD aims to advance disability rights, including health rights, by providing the same rights to disabled persons as non-disabled persons (UNCRPD, 2006). Currently, 147 state party members have ratified this convention and are therefore obliged to ensure that provisions to protect the rights of persons with disabilities are domesticated at a national level (Hanass-Hancock, Grant, & Strode, 2012). Despite the advocacy of health rights in international law, literature indicates that there are discrepancies between national laws and international obligations, and efforts to implement these rights have been limited and in most cases not yet successful (Gloppen, 2008). People with disabilities continue to face discrimination in attaining adequate and appropriate health-care at an equal level to the non-disabled (Evans et al., 2012). Disabled persons access to health-care services and facilities are limited, and minorities within the disabled minority such as people with intellectual disabilities are particularly disadvantaged (Bartlett, 2012). The development of indicators and frameworks that measure and guide state party compliance with international law in human rights achievements are slowly developing, and are increasingly found in literature. However, their existence is limited. Therefore, there is a need for enhanced knowledge on existing frameworks and evaluation of their success in implementing the right to health. Further there
is a need to develop new indicators and frameworks to improve the implementation of human rights in health.

There are two focuses of this paper. Firstly, existing indicators in literature for the successful implementation of the right to health are outlined. Secondly, discussion among scholars on application and evaluation of human rights frameworks to medical and health programmes and existing disability rights is outlined and analyzed. This paper is divided into three parts: Section I – Background and Literature Review; Section II - Jurisprudence from UNCRPD Human Rights Committee; and Section III - Creating a Framework for Using Human Rights Indicators for the Right to Health. In Section I the UNCRPD and Article 25 is outlined and existing literature on the current implementation status of the right to health including frameworks to measure successes in achieving health human rights are reviewed. In Section II broad themes of challenges to implementation of Article 25 and improvement recommendations based on UNCRPD committee jurisprudence is described. Then, the effectiveness of UNCRPD committee jurisprudence is analyzed, and limitations are highlighted. In Section III, based on existing discussion among scholars, suggestions are made regarding development of indicators and frameworks for health and medical programmes.

**Section I - Background**

The purpose of the UNCRPD is to “promote, protect, and ensure full and equal enjoyment of all human rights and fundamental freedoms of persons with disabilities, and to promote respect for their inherent dignity” (UNCRPD, 2006). The convention changed notions of disability which were traditionally seen through lenses of the medical and charity model to a
social model of disability. The medical model of disability views disability as a shortcoming of the individual and inability to perform activities as a result of impairment and a need for a cure (Harpur, French, & Bales, 2012). The charity model of disability posits that disabled persons are victims of circumstance and deserve pitying and should be helped (Addhlaka, 2008).

Alternatively, the UNCRPD (2006) promotes a social model of disability which emphasizes that disability is socially created. It posits that disabled persons are impaired because society does not provide sufficient services to ensure their full and equal participation. An environment that does not support the rights of persons with disabilities should be changed to support such needs (Bartlett, 2012). The definition of a person with a disability in the UNCRPD is those who have “long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (UNCRPD, 2006). In relation to health care, a social model of disability promotes that governments are obliged to enable access to health care services and programmes for disabled persons at an equal status to the non-disabled to ensure their full and equal participation in every aspect of society.

Article 25 of the UNCRPD recognises that people with disabilities have the right to enjoyment of the highest attainable standard of health without discrimination on the basis of disability (Art.25, UNCRPD, 2006). It requires that State Parties take all appropriate measures to ensure persons with disabilities have access to health-services that are gender specific, and include health-related rehabilitation (UNCRPD, 2006). Measures include but are not limited to adopting appropriate legislation, modifying or abolishing existing laws, using private and public organisations to act in conformity with this convention, to undertake
research and design programmes and facilitates to aid implementation, and to train professionals and staff who work with people with disabilities to recognise and implement rights (Art. 4, UNCRPD, 2006).

The sub-sections of Article 25 state that State Parties shall:

“(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons;
(c) Provide these health services as close as possible to people's own communities, including in rural areas;
(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.”

Subsections of Article 25 highlight different components of prominence for persons with disabilities and the right to health. Knowledge of the rights outlined in the subsections are vital for the development of indicators and human rights frameworks which encompass all components of disability health rights for creation of more holistic medical and health programmes.

For the purposes of this paper, indicators are variables that can be used to identify or measure progress in implementation of human rights norms as identified in national policies or legislation and principles in health-care services, facilities, and programmes for persons with disabilities (Bickenbach, 2011, p. 5; OHCHR, 2012). The development of indicators whether quantitative – statistical, or qualitative – categorical, are vital to the process of implementation because they provide the human rights status of State Parties of the UNCRPD, and indicate further action that needs to be taken (OHCHR, 2012). Importantly, they enable human-rights to be measured using international standards, and support the realisation of human rights (OHCHR, 2012).

Bickenbach (2011) posits that for successful indicator development and implementation of the UNCRPD, a strong monitoring process especially data collection, is necessary (p. 3). Five interrelated elements of a monitoring process are outlined; Rights, Goals, Targets, Indicators, and Data Sources. Human Rights Instruments create duties or obligations on one party and entitlements or rights on another (p. 3). Rights create social norms and, “form moral compass of disability policy reforms” (pp. 3-4). Each article of the UNCRPD state human rights specifically for disabled persons. Articles 1 to 4 state the purpose, principles, obligations and
definitions, the middle 27 articles describe areas of human life or experience, and articles 32 to 38 focus on monitoring and reporting (Bickenbach, 2011, p.3). Rights though sometimes vague and abstract, determine policy goals (p.4). While interpretation of wording of each article can lead to inconsistencies, implicitly stated goals enable flexibility in interpreting to suit State Parties specific situations (p.4). Targets are the quantitative and qualitative operationalisation of goals (p. 4). They provide concrete descriptions of content and goals and specify details about the precise social commitment the goal creates (p.4). They are essential because they specify the kind, degree or extent of achievement of a goal (p. 4). However, it is challenging to form a balance between progressive and realistic targets (p.4). Targets can be absolute which are scientifically measurable, or relative which are easily manipulatable to fit policy motives.

The UNCRPD does not specify targets, thereby enabling State Parties to specify appropriate targets (pp. 4 -5). The development of goals and targets are important in the development of indicators, which are derived from targets. For example, if a target is, “reduce mortality rates by two-thirds between 1990 and 2015, the indicator would be under-five mortality rate (p. 5). Measurement of the mortality rate would enable realisation of how much progress has been achieved and will direct and provide a picture of future change. Finally, it is vital to have valid and reliable data relevant to the indicator. Data collection of the demographic variable - disabled persons - is necessary so that comparisons can be made between overall rates and rates for persons with disabilities. It is a significant process in operationalisation of goals and targets (p. 6; UNCRPD, Art. 31).
The OHCHR (2012) has outlined three kinds of indicators - structural, process, and outcome. It encourages its use as a tool for measuring the existence of a state’s commitment, effort, and result in the realisation of each attribute of a right (p. 1).

Structural indicators capture the acceptance and commitment of a State Party in undertaking measures in realising a right (OHCHR, 2012, p. 34). When a state party ratifies a human rights treaty structural indicators aid the assessment of its commitment to incorporating and implementing the rights of the treaty (OHCHR, 2012, p. 34). This could include legal reform and institutional mechanism to promote and protect rights, time frame and coverage of national policy on a human right, and the set up of institutional mechanisms and formal procedures to promote and protect rights outlined in the treaty (p. 34). Structural indicators such as, “the proportion of human rights instruments ratified by the state”, and “number of non-governmental organisations and personnel (employees and volunteers) formally involved in the protection of human rights at a domestic level” are important in monitoring a state’s commitment to realisation of a human right (p. 35). Specifically, in relation to Article 25 of the UNCRPD, its incorporation in domestic laws, national policy, and institution frameworks, strategies and implementation in health and medical programmes enable realisation of the extent to which rights have been achieved and direct action on achievement of rights. Structural indicators enable furthering of human rights by highlighting the governments efforts to hold a right and can hold them accountable for lack of action (p. 35). A resulting policy statement could also enable translation of a human rights obligation to implementable action (OHCHR, 2012, p. 35).

Process indicators differ because they measure “duty bearers’ ongoing efforts to transform their human rights commitments inter desired results” (OHCRC, 2012, p. 36). Such
indicators continuously assess policies and specific measures taken by state parties to shape on-ground practices and the fulfilment of human rights obligations (p. 36). This includes public programmes for development and governance, budget allocations, human rights complains received and redressed, incentive and awareness measures extended by the duty bearer to address specific human rights issues, and indicators reflecting functioning of specific institutions and commitment to realisation of a human right (OHCRC, 2012, p. 36). Importantly, a process indicator links the State Parties measures with the human rights goal and target and acts like a “monitorable intermediate” and has a “cause and effect relationship” between the commitment and results (p. 36). Therefore, process indicators are sensitive to change and are effective in capturing the progressive realisation of a human right. In the development of a process indicator it is important that it conceptually or empirically links the structural indicator (i.e. states human right) to its outcome indicator (p. 37). In relation to the right to health, a process indicator is for example, proportion of children with access to early disability detection and intervention services, would be related to the structural indicator - inclusion of it in policy and implemented through institution in practice, and outcome indicators - proportion of children without access to early disability detection and intervention services. A process indicator must also include information about the effort made by the duty bearer to meeting this obligation (p. 37), such as, proportion of children with access to early intervention services. The figure compared to the target would measure efforts and enable formulation of a realistic, achievable outcome.

Finally, outcome indicators “capture individual and collective attainments that reflect the state of enjoyment of human rights in a given context” (OHCHR, 2012, p. 37). They indicate a state parties achievement of rights. Examples include changes in proportions of labour force participating in social security scheme, child mortality rates, and educational attainments (P.
Because outcome indicators measure the impact of various underlying processes of monitoring and implementation efforts over time, it is the slowest moving indicator (p. 38). For example, lowered rates of disability among infants and children due to environmental factors could indicate increased public awareness and accessibility to early detection and intervention facilities. Outcome indicators can be used to assess whether implementation has been successful in shaping on-the-ground practices that affect individual lives or society wholly.

The concept of a monitoring process and the significance of indicators in achieving human rights (Bickenbach, 2011) has been outlined and three different kinds of indicators (OHCHR, 2012, pp. 34 - 38) have been explained. The literature review highlights efforts made by several parties to monitor and develop indicators in achieving and implementing disability rights as outlined in the UNCRPD. Moreover, the pros and cons of monitoring and indicator development efforts in the realisation and achievement of disability rights are discussed.

**Indicators for the Right to Health: How Effective are Current Monitoring and Implementation Efforts (indicators) in Achieving the Right to Health?**

Existing literature indicates that a small number of State Parties who have ratified the UNCRPD have developed indicators, structural, process, and/or outcome, to successfully implement the right to health in their respective societies. Particularly structural indicators have been developed, while process and outcome indicators are still rare. Literature indicates that some State Parties have structured health-related national laws and policies to reflect international rights as outlined in the UNCRPD. Further, litigation is used as a mechanism to challenge unjust laws and practices to better achieve the right the health. However without
indicators there is little substantive evidence and it is mostly anecdotal or based on isolated studies.

Using Litigation to Achieve the Right to Health

Siri Gloppen (2008) suggests that litigation could be a useful strategy for implementing the right to health for the litigator and society wholly. It is argued that litigation is an effective strategy to hold governments accountable for national laws and international obligations (p.22). Litigation is only effective when a legal rule has been violated, and it is not sufficient to hold governments accountable on the basis that a social good has been violated (p.23). Furthermore, litigation is most effective when health rights are explicitly stated in national laws and legislation, however litigation can also be effective, where permitted, when such rights are not explicitly stated (p. 23). In such situation human rights instruments and international laws would be relied on (p. 23). The concept of accountability was outlined, whereby it was defined as an institution or person entrusted with power and control of resources are obligated to use it considering the best interests of society (p. 22). When the government does not use its power and resources in a just manner, litigation advocates that a rule has been violated and that a social good has been neglected (p. 22). This study aims to assess whether litigation successfully changes policies and implementation that enhances and makes the health system more equitable to benefit members of societies whose rights to health is most at risk or only favours litigants and the privileged patient groups and sectors in society (p.25). The framework for litigations assessment has four inter-related stages (pp. 25-32).
Stages are:

i) claims formation stage - whether or not health right claims make it to court (p. 25)

ii) adjudication state - uncover factors which influence how judges deal with health rights claims in their jurisprudence (pp. 28-29)

iii) implementation stage - government agencies responses to health right judgments and understand whether relevant authorities comply with court orders and it affects policies and legislation (pp. 29-31)

iv) social outcome stage - to understand how litigation has affected overall conditions in society with regard to the right to health (pp. 31-32)

Analyses of findings using this framework found that despite its benefits, litigation is not the best approach to the successful implementation of the right to health because it does not always have a positive effect, and inequalities may occur (p. 24). Poorer people are less likely to litigate, formal recognition of rights in court does not always equate to changes in practice, judges may not have sufficient knowledge on the rights and experiences of disabled persons, some groups may remain privileged over others, and litigation also undermines long-term planning and rational priority setting in health policy (p. 24). Gloppen (2008) developed a framework to analyse and measure the role of litigation in holding governments accountable and successfully implementing the right to health through changes in laws and practice for society wholly. While litigation is more beneficial to the wealthier sectors of society and may not necessarily change social structures for the benefit of the larger society, its benefits especially in advocating health rights and creating the notion that current practices are unfair and need to be improved, should be emphasised.
Similarly, research by Allan Maleche and Emma Day (2014) discuss the role of the law in challenging Kenya’s Anti-Counterfeit Act 2008 and emphasise the significance of litigation in better compliance with international law, particularly successful implementation of the right to health. Kenya’s Anti-Counterfeit Act 2008 prevents counterfeiting, including of medications. Though the controlling of fraudulent products may seem better for the public, in reality it prevents access to affordable, generic medications. Prior to this Act, drugs to treat HIV and AIDS were easily and affordably available to Kenyans. However, since the Act’s enforcement only expensive non-generic medication is available, which is only accessible to wealthier people. Therefore, three petitioners - Patricia Asero, Maurine Murenga, and Joseph Munyi - litigated this act. In challenging this act, three arguments were presented to the court; i) the first argument was that the term “counterfeit,” as provided for in Section 2(d) of the Anti-Counterfeit Act, was too broad and vague, as it encompassed generic medicines produced in Kenya and elsewhere; ii) the application of the three controversial sections of the Anti-Counterfeit Act would result in a violation of the rights to life, human dignity, and health as it limited access to the lifelong generic ARVs; and iii) concerned the use of intellectual property rights laws to control sub-standard medicines. The petitioners were opposed to the sections of the act that prevented the production of substandard and falsified medicine. This was because a large proportion of population affected by HIV and AIDS were unable to afford expensive medication, thereby worsening their health and increasing mortality. The outcome of the litigation was that the right to life, dignity, and health of the petitioner was of more importance than the rights of the patent holder, therefore the availability of generic medication was formally recognised and excluded from the Anti-Counterfeit Act 2008. The outcome of the case was improved access to health for Kenyan society in increasing availability of affordable, generic medication, and the potential of improving the right to health for people with HIV and AIDS in the rest of Africa. Though, a
framework was not developed this example highlights the effectiveness of litigation and collaboration of health experts, and advocacy in the successful implementation of the rights to health. The development of a framework incorporating rights, targets, goals and indicators would direct and guide other countries facing problems regarding the right to health to use this as a strategy to collect data and develop implementation plans to improve health care.

Similarly, research by Peter Bartlett (2012a; 2012b) emphasises the adoption of international law in developing procedural and outcome indicators for the right to health. Similar to the process of litigation to oppose unjust societal structures, he emphasises the role of human rights bodies in adopting human rights of international conventions in directing national legislative changes, and eventually on-ground practices (2012a, p. 755 - 761). In Europe, especially the United Kingdom, the compulsory detention and medical intervention of people with mental illness is a problem and violation of the right to health (2012a, p. 754). Often people with mental disabilities are not free to make their own decisions and are forced to take treatments due to the perception that it is better for them. (2012a, p.754) Gardner found that out of 65 patients, the detention of only half were justified, while a study by Priebe found that the compulsory detentions of only 40 out of 396 people was justified (Priebe 2012b, p. 834).

As a violation of human rights, several of these cases (Gardner et al., 1999; Priebe, 2009) have been taken to the European Court of Human Rights to attempt to shift from medicalising people with mental disabilities to viewing them as autonomous beings. Bartlett (2012a) emphasises that though laws and practices in the United Kingdom are discriminatory towards people with mental disabilities, it is the role of the European Court of Human Rights to prescribe appropriate standards using the UNCRPD and other international law, and monitor that it is successfully implemented (2012a, p. 842). Further he argues that the role of law is
not only symbolic - in shaping social norms - but also in shaping on ground practices. Although Bartlett (2012) does not develop a framework or guiding standards, he reminds people of their health rights, emphasises the power of the European Court of Human Rights in changing health related legislation and practices, reinforces that change is a lengthy process, and encourages efforts to continue to implement health human rights. While a reminder is useful, a framework or standardised guidelines could encourage more people to challenge laws and facilitate human rights bodies to successfully implement the right to health.

**Developing Frameworks to Achieve The Right to Health**

Some researchers have developed process indicators for the purpose of measurement, and to guide and direct future improvements in health human rights. Frameworks to assess legislation, policies, and specific measures taken by state parties to implement its commitment to the right to health have been developed and have successfully measured functioning of specific institutes and the legal systems in achieving health human rights in compliance with the UCNRPD.

Sharan Brown and Michael Guralnik (2012) are concerned that despite its significance in detecting, minimising, and preventing disability and secondary consequences, early intervention for infants and young children with disabilities are scarce worldwide, therefore they created a framework to encourage its implementation (p. 271). The framework that was developed encourages a whole of government approach, that is, the co-ordination and integration of several sectors and organisations within a society. It also aims to educate concerned health professionals on how to better implement early intervention practices and facilities (p. 281). The frameworks outlines ten detailed principles to achieve this including
that early detection and identification procedures are in place, surveillance and monitoring of
children takes place, and ensuring that all recommendation to families about intervention
practices are evidence based (pp. 280 - 283). The framework complies with international
disability law and aims to provide guidance and a set structure that countries lacking in early
intervention resources and practices can use when implementing this right to health (p. 280).
Not only can it be used to structure early intervention programmes, but also monitor the
process and make realistic assumption about the outcome and its potential achievement of
international health obligations (p. 280). While outcome guidelines to realise health human
rights and guide their implementation have been developed, the inclusion of a reporting
system, and a body to make recommendations and ensure consistency of adherence across
countries - which the researchers have not mentioned - would strengthen the implementation
of the right to health.

Similarly, Evans, Howlett, Kremser, Simpson, Kayess, and Troller (2012) explored existing
problems with health services in Australia and developed a five-tired framework - NSW
Health Service Framework to Improve Health Care of People with Intellectual Disability.
People with intellectual disabilities (ID) are more likely to face discrimination due to
increased vulnerability and marginalisation, and lack of professional knowledge than people
with physical or other disabilities (pp. 1098 - 1099). Further, it is argued that the medical
model is still dominant in the Australian health system in dealing with people with mental
disabilities (p. 1102). Therefore this framework aimed to address the health needs of people
with ID and recommend a specialist ID health clinic model so they have access to the same
health rights as people with other disabilities and the non-disabled (p. 1100). Australian
legislation and international conventions - structural indicators - which emphasise a social
model of disability were used in the development of this framework. The five structures of the model are (pp. 1100 - 1102):

i) “Public Mental Health Services - to increase the number of clinicians who work in mental health and specialise in ID, and specific facilities for people with ID” (p. 1100)

ii) “Public Health Service Workforce - increase training for health professionals to enhance confidence in working with people with ID” (p. 1101)

iii) “Service Evaluation - data collection of prevalence of ID and mental illness should be increased” (p. 1101)

iv) “Service Access - Increase medical interventions for people with ID as other people in society by developing specialised mental health services for people with ID” (pp. 1101- 1102)

v) “Mental Health Policy - Contain specific acknowledgement of co-occurring ID and mental illness in National Mental Health Strategy and National Disability Strategy” (p. 1102)

This framework focuses on empowering people with disabilities, especially ID, with a more responsive service system, including individualised funding and affirming the right to effective supports that reflect needs. Furthermore, it provides qualitative and procedural indicators in successful implementation of the right to health through encouraging collaboration between several organisations in society, increased financial resources, data collection, policy changes, cultural change, and training and education (pp. 1102 - 1103). While this would be an effective indicator for the realization of the right to health, it would be greatly improved by the development of targets for each of the five sections of the
framework, and timeframes within which they should be reached; future research should explore this further.

A South African study by Isabell Schierenbeck, Peter Johansson, Lena Anderson, and Dalena van Rooyen (2013) also developed an AAAQ framework in monitoring the implementation of the right to health. Although Article 25 of the UNCRPD emphasises equal access to health care, the researchers found that in South Africa people with mental disabilities were marginalised and had even lower access to mental health services (p. 111). Eleven semi-structured interviews with health professionals and administrators were conducted (p. 111-112) and it was found that though South African legislation - the Mental Health Care Act 2004 required equitable access and distribution of mental health care treatment and services - there were barriers to implementation in practice such as inadequate support community-based services, shortages in hospitals, lack of ability to treat comorbidities, stigmatisation and insufficiently trained medical staff (p. 112). The AAAQ framework recognises four interrelated and overlapping elements as necessary for the implementation of the right to health (p.113-117):

i) “Availability - lack of staff, lack of facilities, and lack of community services and preventative care” (pp. 113-114)

ii) “Accessibility - lack of transport, lack of information, stigmatisation, and traditional cultural beliefs of the community” (pp. 114-116)

iii) “Acceptability - lack of cross cultural understanding among staff, and traditional cultural beliefs of staff” (p. 116)

iv) “Quality - lack of properly trained staff, and lack of organisational capacity” (pp. 116-117)
The AAAQ framework extends beyond availability to accessibility, acceptability and quality, and indicates barriers to the enjoyment of the right to health for people with mental disabilities (p. 117). Analysis of mental health services using this framework would enable measurement of current flaws in the system for persons with mental disabilities. Knowledge is significant to monitor, guide future direction and enable appropriate changes in laws and practices. While this analysis framework was used to monitor specifically mental health services in South Africa, future research would benefit from adopting it and extending it to monitor other health services. Further, within South Africa, it would be useful to set targets and indicators to better implement the right to health and fulfil international obligations.

Jonathan Cohen and Tamar Ezer (2013) aimed to improve existing practices of disabled persons patient care to better apply human rights principles therefore developed a new concept and framework for ‘patient care’. The researchers aim to develop strategies to enable patients to play an active role in shaping delivery models and to comply with international conventions (p. 14). The framework focuses on both the patient and provider (p. 17). It encourages theoretical and practical application of general human rights principles in the context of patient care. In the framework patients are placed at the centre of focus on discrimination and social exclusion, while conflicting obligation of providers to the patient and the state are recognized and, and systematic issues and state responsibility also examined. It also includes patient rights to liberty and non-discrimination, key provided rights, views patient rights as more than consumers to humans with rights, recognises limitations of the right to health due to policy obligations and competing resources, draws on accepted international norms and jurisprudence, and it provides legally recognised and globally accepted norms and procedures for identifying systematic issues and enabling redress and mobilisation (pp. 16-17). The six standards are the most common human rights violations for
the health and human rights of marginalised populations (p. 15). They are specific to the research project and used to develop the framework to improve human rights in health care (p. 15). They are:

i) “Using medical skills or expertise on behalf of the state to inflict pain or physical or psychological harm that is not a legitimate part of medical treatment”

ii) “Subordinating independent judgment, whether in therapeutic or evaluative settings, to support conclusions favouring the state or other third party”

iii) “Limiting or denying medical treatment or information related to treatment of an individual to effectuate the policy or practice of the state or other third party”

iv) “Disclosing confidential patient information to state authorities or other third parties in circumstances that violate human rights”

v) “Performing evaluations for state or private purposes in a manner that facilitates violations of human rights”

vi) “Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals”

These six standards shed light on human right abuses in patient care and provide a framework for preventing abuse by resolving dual conflict - conflict between patient and state values - in a fair and transparent manner (p. 8). While this model is effective to an extent in guiding non-discriminatory treatment, there are limitations including leaving out rights of stakeholders in healthcare delivery, focusing on patients while healthcare delivery focuses on everyone, and
free choice rather than improvement of the health care system (p. 14). Though exercising free choice preserves the rights of an individual, it may slow, restrict, or prevent the process of improving the health care system for the good of a larger public good when there are limited resources (p. 14). These limitations outlined by the researchers should be considered to develop more effective indicators, frameworks and shape health and medical programmes.

Australian researchers Gemma Carey, Brad Crammond, and Roybn Keast (2014) discuss a ‘joint up government’ (JUG) approach in implementing the right to health. The aim of JUG is to integrate government departments, agencies and actors outside of the government to change social societal structures to achieve health and other human rights (p.1). Therefore, the researchers aim to identify implications of existing ‘Joint-up Government’ (JUG) frameworks and discover how to strengthen such social determinants of health and increase efficiency of interventions (p.1). Methodology includes discussion of the Health in All Policies Approach (HiAP) and analysis of health inequalities in the UK using the Maromot Review 2010 to implement public health beyond advocacy to shaping government structures (pp. 8-9). The researchers argue that health promotion improves by the “use of institutions and structures of authority and collaboration to allocate resources and coordinate and control joint action” (p. 4). Current joint up government approaches use ‘instrumental process-based interventions’ (IPIs) to create healthier policies (p. 2). There are two IPIs - Fairness agenda and Health in all policies (HiAP) (p.2). ‘Fairness Agenda’ ensures that there is fairness in all policies to create a ‘cultural-institution’ by uniting stakeholders behind a common goal (p.2).

HiAP is a public intervention that aims to create JUG, but is explicitly health focused (p.2). Literature analysis revealed that in South Australia the HiAP approach is used (pp. 10-11). A Health Lens analysis operates to ensure that HiAP is applied to all new government policy
The analysis provides primary means for incorporating health into other government sectors to ensure that health is included in all policies (p. 7). Though this is a thorough method of incorporating health in all polices, it does not have the legislative power from preventing a policy from being developed. Five areas of concern were identified - operational level, nature of control, top/bottom focus, instruments and membership (p. 9). It was found that successful joint up initiatives were specific in that the purpose of what was hoped to be achieved and the context - the system in which change needed to occur were outlined (p. 10). Further, in order to enhance success the establishment of an inter-departmental committee was significant in increasing accountability, implementation and decreased segregation that resulted from certain departments holding power and responsibility of implementing HiAP (p.11). Collaboration also decreased pressure and excessive costs and therefore would more likely be successful in health promotion (p.12). The researchers also caution the use of various stakeholders and policy makers who would have different solutions to dealing with health problems, and emphasise their inclusion would require interaction and negotiation (p.11). Further it is suggested that interventions should be ‘fit-for-purpose’ and cannot be replicated from context to context (p. 10). Overall, the use of JUG especially HiAP was highly recommended because it would transfer ineffective instruments to effective ones by creating supportive architecture to ensure that there are no discrepancies between goals and mechanisms used to achieve them, establish stricter mechanism and arrangements that enable more than sharing information to collaboration, decentralise control, enable training and skill development in health, increase accountability and incentive mechanisms to take action, and lead to an increase in resources such as information sharing (p.12). Both the HiAP and a Marmot review revealed that JUG has a positive impact on individual policies and extends to better shape government structures and facilitate the implementation of these policies (p. 12). Research indicates that while HiAP policy approach is an effective process indicator the
successful implementation of the right to health, there is room for improvement as recommended by researchers. The aim of JUG is to include health in all policies across the government thus the next step would be to set targets, indicators and collect data to ensure policy is put into practice. Furthermore, it is only specific in Australia, and could be adopted in other countries if generalised or personalised.

The Right to Health so Far….

Thus far research has indicated that social determinants of the right to health are increasing, especially since the creation of the UNCRPD. Further, successful indicators for the implementation of the right to health though limited, have been developed (Brown & Guralnik, 2012; Evans, et al., 2012; Schierenbeck et al., 2013; Cohen et al., 2013; Carey et al., 2014). Litigation to challenge unjust laws plays more than a symbolic role and is effective in holding governments accountable for the lack of achievement to the right to health, enhancing advocacy, and encouraging practical implementation. Litigation has been used in Kenya and other resource limited countries (Gloppen, 2008; Malleche & Day, 2013). The development and adoption of conventions such as the UNCRPD also better enhances social determinants to the right to health even though it is a slow process. This is especially the case in the United Kingdom and the role of the European Court of Human Rights. Five frameworks have been developed as indicators to successful implementation of the right to health as per the UNCRPD. A framework has been developed to better implement early detection of disability and intervention facilities and access in Spain and Hungary (Brehmer-Rinderer et al., 2013). Two frameworks have been developed to measure and as a guidance to the better implementation of mental health services in Australia and South Africa respectively (Evans, 2012; Schierenbeck et al., 2013). Another framework has been developed in the United States to prevent -patient discrimination in health care (Cohen &
Ezer, 2013). Lastly, a HiAP framework was developed in South Australia, aiming to include health in all social policies to ensure that all sectors of society collaborate to improve health (Carey et al., 2014). Only a few indicators have been developed for the right to health. It is vital that limitations of existing indicators are realised and frameworks improved to better represent international human and disability rights and fulfil international obligations.

The three indicators to the right to health - structural, process and outcome - rely on the UNCRPD, and other international law in shaping national policies, aim to monitor the implementation of human rights and measure efforts to achieving the right to health, and aim to improve the lives on individuals, society wholly, and transform social processes. Structural indicators have been in play for many years, the development of process indicators is only in its beginning stages and should be further developed to better comply with international law especially the UNCRPD. The development of outcome indicators is limited as change and the achievement of health human rights is a slow process. It is therefore vital to have a strong monitoring process including the setting of goals, targets, indicators, and collecting appropriate data to increase the efficiency of social change and achieving the right to health.

The first aim of this paper was to discover if there are a set of indicators to the successful implementation of the right to health (Article 25 CRPD). The second aim was to identify discussion among scholars of how to apply a human rights framework to assessing medical and health programmes. Through discussion of findings it also aims to bring to the forefront how to apply a human rights framework to medical and health issues. Based on past research it is argued that current indicators as discussed in this paper are successful in bringing to forefront achievements and limitations in health human rights. This realisation is useful in guiding future action for the achievement of the right to health. To better implement social
determinants of the right to health, it is essential that learnings are made from limitations of current indicators and frameworks, and more health indicators and vigorous frameworks are developed for the successful implementation of the right to health.

Section II - Jurisprudence from UNCRPD Human Rights Committee

This section discusses jurisprudence from the UNCRPD Human Rights committee in the form of concluding observations to initial state reports on efforts on the implementation of the right to health. Out of 147 state parties who have signed this convention, 70 initial state reports have been written. The UNCRPD committee has produced concluding observations of 19 reports. This section excludes the concluding observations for the state parties of Belgium, Ecuador, and Mexico due to missing translations in English.

The Committee on the Rights of Persons with Disabilities is an independent body of 18 independent experts who monitor implementation of the Convention of the Rights of Persons with Disabilities (OHCHR, 2012). The independent experts serve in individual capacity and not as government representatives. However, they are nominated by States (OHCHR, 2012). State reports include information on how the rights enshrined in the convention are being implemented. It is expected that states report within two years of ratifying to approve and give formal sanction to the convention, and thereafter report every four years. The role of the committee is to examine each report and make suggestions and general recommendations on the report. The recommendations are forwarded to state parties concerned as concluding observations.

State party reports are detailed and provide specific examples about achievements, policies, and statistics, including a summary of successes and challenges of the UNCRPD
implementation processes in their specific country. However, there is no mention from the committee monitoring on whether the information is accurate and complete. It is up to civil society to actively inform the Committee of perspectives of the larger community. They can provide ‘shadow reports’ that highlight gaps, inconsistency, and errors in the State Reports. Concluding reports emphasise concerns and provide recommendations to guide, and direct state parties on track to continue efforts to successfully implement the UNCRPD.

The concluding observations are divided into three parts. Part I is an introduction including the date of CRPD meeting in which the initial report of the particular state party is discussed and concluding observations made. Part II explores positive aspects of the state reports, the successes of implementation of UNCRPD, and commends the state parties’ current efforts and achievements. Part III is the longest section and comments on principle areas and concerns, obligations under UNCRPD and makes recommendations for the better implementation of this convention. For the purposes of this report Part III – Principle Areas of Concern and Recommendations – is mainly used. Concerns and recommendations in relation to Article 25 – the Right to health – will be described.

Broad thematic trend analysis of the committee’s concerns regarding implementation of Article 25 of the UNCRPD has indicated that there are ten specific areas of concern in health equality between the disabled and non-disabled. Thematic trends were deciphered from implementation concerns mentioned in the concluding observations on the United Nations Human Rights Commission website. The countries which expressed concerns are cited beside trends.
i) Physical and systematic barriers: There is a dearth of accessible materials and equipment to support medical procedures and services to support and treat persons with disabilities (Argentina, Costa Rica, Denmark, El Salvador, Paraguay)

ii) Lack of specialists and trained professionals: Some countries lack trained and general specialists in specific medical conditions. Professionals are also untrained in the right to health of disabled persons through a human rights lens (Argentina, Paraguay)

iii) Restriction of legal capacity: Persons with disabilities are unable to exercise freewill, autonomy and give informed consent on medical treatment and other health related issues (Argentina, China, Costa Rica, El Salvador)

iv) Mental capacity: Health resources are lacking for people with psychological, mental, and intellectual disabilities, and these groups are particularly discriminated against in services and treatment (Denmark, New Zealand, Republic of Korea)

v) Rehabilitation: Persons with disabilities have lack of access to rehabilitation facilities (Argentina, Peru, El Salvador)

vi) Sexual, reproductive, and HIV policies: Disabled persons are excluded in sexual, reproductive and HIV policies and services although persons with disabilities are disproportionally affected (Costa Rica, El Salvador, New Zealand, Paraguay)

vii) Limited Information: Disabled persons living in rural areas lack information about the right to health, and persons with disabilities are excluded from public health campaigns (Costa Rica, El Salvador, Peru)

viii) Health insurance discrepancies: Persons with disabilities, especially mental and intellectual disabilities are discriminated against in access to health insurance compared to the non-disabled (Peru, Republic of Korea)
ix) Discrimination of Indigenous groups: Indigenous persons have a higher prevalence of disability due to disadvantage, and lack access to healthcare services (New Zealand)

x) Healthcare for Children: Early detection programmes of deafness in children are lacking (Costa Rica, Peru)

UNCRPD committee recommendations aim to solve current challenges and guide state parties to better implement the right to health. Ten significant committee recommendation were found in the concluding observation reports for the successful implementations of the right to health. Again, citations refer to concluding observations of respective countries that contain these recommendations. They are as follows:

1. Create comprehensive health care programmes for persons with disabilities including rehabilitation (Argentina, China, El Salvador)

2. Develop alternatives to medical models of health and train healthcare professionals and hospitals on a social or community model of disability, especially in mental healthcare (Argentina, China, Costa Rica, Denmark, Peru)

3. Legislations and policies in state parties should be changed where necessary to improve the human rights of persons with disabilities in health care, especially regarding freewill, informed consent, freedom from involuntary treatment, and equal access to health insurance (Argentina, China, Costa Rica, El Salvador, Peru, Republic of Korea)

4. Health policies, programmes, and services should include sexual, reproductive, and HIV/AIDS healthcare for persons with disabilities (Costa Rica, El Salvador)

5. Improve health care services for people with mental disabilities to ensure their equal access to highest attainable standard of health (China, Denmark, Paraguay)
6. Public health campaigns should include and be accessible to persons with disabilities such as cervical cancer, HIV/AIDS, and breast cancer (Denmark, El Salvador)

7. Gender perspectives on healthcare for disabled persons should be developed and improved, especially for women in reproductive and sexual health (Costa Rica, Paraguay, El Salvador)

8. Statistical data on persons with disabilities should be increased so better planning can be facilitated to improve access and health care services for disabled persons (El Salvador)

9. Measures including legislative and policy reform should be taken to enhance health outcome for indigenous persons with disabilities (New Zealand)

10. Measures should be taken to implement services of early identification of disability, including deafness, to prevent further disability (Peru)

The type of concern depends on whether a country is developed or developing. Developing countries emphasize increased health-care accessibility whereas developed countries particularly look at rights inclusion and people with mental and intellectual disabilities. The breakdown of concerns and CRPD recommendations for 16 countries are as follows:

i) Argentina

The concluding observations to Argentina’s initial state report highlights concerns that:

i) People with disabilities have unequal access to healthcare services due to systematic and physical barriers such as dearth of accessible materials, a lack of health-care professionals trained in the human rights model of disability

ii) People with mental disabilities are particularly discriminated against due to the ineffective implementation of the National Mental health Act and lack of implementing regulations and a missing review body
iii) A lack of clear cut mechanism for ensuring that people with disabilities exercise legal capacity in decision-making about treatment, and free and informed consent for any type of medical treatment before it is administered.

It is recommended that comprehensive health-care programmes for persons with disabilities including habilitation and rehabilitation is developed, and training is provided for health personnel to realise the right to health of persons with disabilities, and hospitals and health centers are accessible to persons with disabilities. It is also recommended that an implementation strategy for the National Health Act is adopted, and that people with disabilities are given their free and informed consent for any type of medical treatment before it is administered.

ii) Australia

There is no mention of Article 25 in Part III – Principle Areas of Concern and Recommendations, suggesting Australia’s efforts to equal health care for disabled and non-disabled are either not mentioned in the state parties report, or the government is progressive in this area.

iii) Austria

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Austria.

iv) Azerbaijan

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Azerbaijan.

v) China

The concluding observations to China’s initial state report highlights concerns that:

i) The Draft Mental Health Act does not respects persons with disabilities and involuntary commitment system to health treatment currently enforces
It recommends that measures ensuring all health-care and mental health-care services provided are based on free and informed consent of the individual concerned are adopted, and laws permitting involuntary treatment and confinement, including upon authorisation of third party decision-makers such as family and guardians are repealed. It is also recommended that a wide-range of community-based services and supports that respond to needs expressed by persons with disabilities and respect the persons’ autonomy, choices, dignity, and privacy, including peer support and other alternatives to the medical model of mental health are developed.

vi) Costa Rica

The concluding observations to Costa Rica’s initial state report highlights concerns that:

i) Disabled persons lack access to general and specialised health services

ii) A medical rather than community or social model approach to mental health care is implemented

iii) Restricted access to health facilities due to no progress in acquisition of medical equipment, fittings and facilities

iv) Persons with disabled persons are excluded in sexual and reproductive health policies, and women and children with disabilities are disproportionately affected.

v) No mechanisms have been established to ensure that all services provided to persons with disabilities are delivered with free and informed consent.

The committee recommends that efforts are made to ensure that all health policies, programmes, and services, including in sexual and reproductive health and those related to HIV/ AIDS are fully accessible and incorporate a gender perspective in a rural and community level. It is also recommended that people with disabilities give their free and informed consent through appropriate mechanisms before receiving health services of any kind, and a community-care model national policy be developed and implemented.
vii) Denmark

The concluding observations to Denmark’s initial state report highlights concerns that:

i) People with psychological disabilities have a life span of 15-20 years shorter than people without psychological disabilities.

It recommends that people with disabilities, particularly people with psychological disabilities have equal access to highest attainable standard of health including by providing adequate and accessible health care services needed by persons with disabilities. It also recommends that health professionals and officials in the public health authority are trained on the right to free and informed consent.

viii) El Salvador

The concluding observations to El Salvador’s initial state report highlights concerns that:

i) People with disabilities have lack of access to health – especially in sexual and reproductive health due to lack of equipment for obstetrical and gynaecological care

ii) Lack of information about the right to health of persons with disabilities in rural areas

iii) Lack of availability of community rehabilitation services

iv) Medical procedures are not conducted with the free and informed consent of persons with disabilities.

It recommends that legislative measures are taken to protect persons with disabilities against discrimination in health matters including access to health insurance schemes, and public health campaigns directed at persons with disabilities of different ages, genders including HIV/AIDS prevention care, and campaigns to prevent breast and cervical cancer. It is also recommended that plan are adopted and resources are allocated for the accessibility of health care services and equipment suitable for use by all, statistical data
on persons with disabilities for better planning and facilitation of their access to health-care services and identify their options to community rehabilitation services produced, and measures to ensure persons with disabilities can exercise their rights to free and informed consent regarding medical treatment adopted.

ix) Hungary

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Hungary.

x) New Zealand

The concluding observations to New Zealand’s initial state report highlights concerns that:

i) barriers still exist preventing persons with disabilities especially intellectual disabilities from full access to health care services, particularly sexual and reproductive health care

ii) Maori people have poorer health outcomes in New Zealand and have a higher prevalence of disability due to poverty and disadvantage

It is recommended that further measures are taken to ensure access to full health-care for persons with disabilities, and to enhance health outcomes of Maori and Pacific persons with disabilities.

xi) Paraguay

The concluding observations to Paraguay’s initial state report highlights concerns that:

i) there is scant information on health services, particularly at a community level e.g. HIV related services for persons with disabilities

ii) there is poor accessibility in specialists and general medical services including barriers preventing physical facilities, medical equipment and furnishing

iii) discrimination in services in the provision of sexual health and reproductive services
It recommends that the state party take necessary measures to ensure that all health services are fully accessible to persons with disabilities at all levels – at a community level and to incorporate a gender perspective.

xii) Peru

The concluding observations to Peru’s initial state report highlights concerns that:

i) there are no rehabilitation services for 81% of the population

ii) only 1.42% of persons with disabilities are covered by social security programmes

iii) there are a lack of health services in rural areas and limitations to Comprehensive Health Insurance

iv) early detection programmes of deafness for children in order to minimise and prevent further disabilities are lacking.

The committee recommends that legal frameworks be reviewed so health insurance companies and private parties do not discriminate against persons with disabilities, health personnel are allocated resources and trained to comply with the right to health care of persons with disabilities and ensure that hospitals are accessible to disabled persons, services of early identification of disability particularly deafness are designed to minimise and prevent further disabilities.

xiii) Republic of Korea

The concluding observations to the Republic of Korea’s initial state report highlights concerns that:

i) persons with mental disabilities are discriminated against in insurance facilities of - article 732 of the state parties commercial act recognises life insurance contracts for persons with disabilities only if the person “possesses mental capacity”.
It recommends that the state party repeal article 732 of the Commercial Act, and to withdraw its reservation to the provision of article 25 (e) of the Convention regarding life insurance.

xiv) Spain

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Spain.

 xv) Sweden

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Sweden.

xvi) Tunisia

There is no mention of Article 25 in the UNCRPD Committee’s concluding observation of the initial report of Tunisia.

The UNCRPD committee’s concluding observations of state reports indicate that there are numerous gaps at varying levels in different countries which prevent persons with disabilities from enjoying the right to health at an equal status to the non-disabled. These issues range from lack of equipment suitable to disabled persons to discriminatory laws and procedures that act as social barriers to the health of disabled persons.

The Committee’s concerns are vague and brief compared to state parties reports which are detailed in their implementation efforts of the UNCRPD. Nevertheless, they are valuable, and provide direction to specific state parties on how to improve health for disabled persons and are based on information provided in the state parties’ initial report.

Though state parties have made an effort to inform the Committee of the successes and failures on the incorporation of this Convention, there are limitations. Each article is briefly
explained in the state party reports. However, there is no indication that all issues regarding the implementation of the Convention are highlighted and put in the forefront. For example, in the Australian initial report there is no mention of disabilities among the Aboriginal population and an indication of how indigenous disabled person’s needs are met. Perhaps disabled Aborigines have equal access to health-care and right to health measures are equal to the rest of the population, but evidence suggests otherwise (Treacy, North, Rey-Conde, Allen, & Ware, 2015, p.11). Thus, information presented in the report is not always accurate nor a complete depiction of the disability-health situation in countries.

Another limitation is the discrepancies in content of state party initial reports and UNCRPD Committee concluding observation. Observation of Article 25 of initial state party reports and concluding observations has indicated that often the state party has highlighted greater challenges to implementation of the right to health, and committee does not always acknowledge all aspects. Further, recommendations are brief and only provide direction but they do not suggest successful frameworks or provide indicators for successful human rights achievements for disabled persons in health. This could result in disparity and inconsistent achievement in health through a social lens across UNCRPD signatories. This suggests the need for a General Comment on the right to health from the UNCRPD Committee. This is a common method for UN Committees to expand on the rights and obligations in a particular convention article, and may be particularly useful for Article 25 implementation.

These limitations could also be solved by properly aiding state parties in identifying successful measures to improve disabled persons’ health care. A solution is the development of human rights indicators and specific frameworks for the implementation – of challenging aspects and gaps –of this Convention. Thus, it is vital firstly that, human rights indicators are
developed to measure and quantify successful implementation of a human-rights health model, and secondly, frameworks are developed to implement legislation, policies, procedures, and programmes in alignment with the terms of international disability law as outlined in this convention.

**Section III – Creating Human Rights Indicators and Frameworks for the Right to Health**

Existing literature on the monitoring and indicator development of Article 25 and concluding observations of state reports indicate that though efforts to meet international human rights obligations are being made, they have not yet been fully successful in achieving the right to health. Literature analysis indicates that although structural, process, and outcome indicators are slowly developing state Parties are still in the process of adopting the UNCRPD into national legislation and policies (Gloppen, 2008). Though frameworks have been developed, they are limited in accessibility and effectiveness (Brehmer-Rinderer et al., 2013; Carey et al., 2014). Further, the establishment of set monitoring processes inclusive of rights, goals targets, indicators and a data collection mechanism is limited and lack of monitoring procedures could be restricting and decreasing the efficiency of the achievement of the right to health for disabled persons (Bickenbach, 2011). Lastly, while some changes have been made, efforts are still far from securing the right to health. The following section includes a discussion of limitations of existing indicators, frameworks, monitoring and implementation mechanisms as outlined in the literature review.

Three studies indicated that litigation is an effective tool to successfully implement human rights frameworks in health and medical programmes. The study by Gloppen (2008) emphasized the benefits of litigation to hold government accountable and highlighted both
the successes and failures of this method of social change. The development and application of a litigation framework and analyses of findings indicated that litigation is successful in holding governments accountable for non-compliance to international human rights treaties and obligations and when a social good is violated (p.22 - 25). It is effective when an explicit health right stated in national legislation is not reflected in practice but when a right is not explicitly stated relevant international law can be relied on to ensure governments use resources for the best interest of society (p. 23). However, findings also indicated that litigation has its drawbacks in achieving health human rights. Some negative effects and inequalities are a consequence of litigation (p. 24). Poorer people are less likely to litigate, legal recognition does guarantee changes in practice, privileged groups remain privileged, and the long term planning in health care is undermined (p. 24). Similarly, a Kenyan study by Maleche and Day (2014) had similar findings. Kenya’s Anti-Counterfeit Act 2008 litigation resulted in affordable access to medication and preservation of the dignity and health of the petitioner. Again, though litigation was symbolic, it did not guarantee practical change in society, which would only result from implementation efforts of civil society. Peter Bartlett (2012a; 2012b) also discussed the role of litigation in domesticating international law. He emphasized that the adoption of disability inclusive laws is the first step and suggested that practical changes would follow (2012a, p. 755).

Overall, while litigation is beneficial in holding government accountable, and revealing lack of legal and practical compliance to human rights and international laws, it is not effective in improving health-care wholly and its practical benefits are limited. These isolated cases have provided suggestions that can be incorporated which could enable dynamic change as opposed to limited successes. For the development and successful implementation of new human rights frameworks for medical and health programmes and limitations revealed by
these studies should be addressed. Litigation is symbolically useful and has the potential to create social norms and the notion that there is a need for better human rights to change current practices.

Five studies found in literature have indicated that process indicators in the form of frameworks have been developed to implement human rights in medical and health programmes. Brown and Guralnik (2012) developed a framework to encourage the implementation of early intervention services for children to prevent and lower rates of secondary disability. The ten-principle framework complied with the UNCRPD, expressed a social model of disability, and encouraged education and training of health professionals (pp. 280 - 283). Findings indicated that the framework was useful in providing guidelines to achieve disability rights in health care. However, a lack of reporting system and monitoring body could lead to inconsistencies in interpretation and adherence, and therefore may lead to inconsistencies in standards of health care for disabled persons. Evans et al. (2012) developed a five-tried framework to improve health care for people with intellectual disabilities, a marginalised group. Although the framework incorporated human rights legislation, national and international, it acts merely as a guideline and does not provide achievement indicators or a timeframe for implementation, thereby decreasing its efficiency. Similarly, Schierenbeck et al. (2013) develop an AAAQ framework in South Africa to improve access to mental health services. Analysis of mental health services using framework indicated gaps in existing practices and was effective in monitoring and providing information (p. 8). This framework was effective in South Africa, but how to adopt in different countries to have the same success in advancing human rights healthcare is a challenge. Cohen and Ezer (2013) also developed a six-standard framework to apply human rights principles in patient care. Findings indicated that while it aimed to resolve dual conflict between patient interests and
the government’s interest, it was not so effective in practice due to limited resources (p. 15). Lastly, an Australian study by Carey et al. (2014) developed a JUG approach to implement health in all policies across all government departments. Again, while this approach was highly successful in improving government policies to reflect health needs, there were sometimes challenges in achieving this, and it did not equate success in practice but depended on the relevant governmental department to make change (p.12). However, a benefit was that when using JUG, goals were set in achieving health human rights (p.12). All studies highlight that frameworks are limited in determining how to effectively implement these rights in health and medical programmes in practice.

Overall, frameworks are not always adhered to, do not always bring about necessary legislative and policy change, and if changes in legislation and policy result then there is no guarantee of implementation in practice. While frameworks are useful in guiding action, a reporting and monitoring body would encourage action and achieve the right to health. The setting of realistic timeframes would enhance efficiency of action. Moreover the development of goals, targets, and indicators would provide a qualitative and ideally quantitative figure to meet, thereby increasing the likelihood of successfully achieving human rights in health. It is also important that frameworks are adopted in specific countries due to different culture, politics, and functioning of countries, it would be difficult to translate one single framework from country to country (Schierenbeck et al. 2013). Thus, it is recommended that guidelines be adopted by State Party governments, but goals, targets, and indicators be developed in respective countries to suit social environment and social progress. However, guidelines should be viewed critically and adopted carefully. Although the ticking of boxes on guidelines checklists is important, it is no use adhering to frameworks if it does not improve lives in practice. Limited availability of resources would make it necessary to discover how
both governmental international obligations and individual human rights could be met; a middle ground would have to be sought for a more holistic and complying framework and impact. It would be important to find a balance between adhering to frameworks and improving social environments and the experiences of disabled persons to better bridge the gaps between theory - international laws, and practice - lived experiences of disabled people in their social environment. It is thus vital to ensure that frameworks are shaped in a manner that will enable them to be successfully implemented in relevant countries. Further, plans to implement should be developed inclusive of targets, goals, and indicators to improve the monitoring process, relevant and appropriate information is collected, and for better guidance to incorporate human rights in health and medical programmes in practice.

The following example of goals, targets, indicators and a data source for a term of article 25, as outlined earlier in the paper, highlights the benefits of indicator development in ensuring the realisation of human rights in healthcare.

Table 1: The following table discussing how to Monitor the UNCRPD is adopted from Bickenbach’s paper and provides a practical example of goals, targets, indicators, and data sources (Bickenbach 2011, p.7)
<table>
<thead>
<tr>
<th>Convention GOAL</th>
<th>Target</th>
<th>Indicators</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>States Parties recognize that persons with disabilities have the right to the</td>
<td>Ensure that people with disabilities have the highest attainable</td>
<td>Proportion of persons with disabilities in need of appropriate health care</td>
<td>Surveys, medical records</td>
</tr>
<tr>
<td>enjoyment of the highest attainable standard of health without discrimination on the basis of disability.</td>
<td>the highest attainable standard of health without discrimination on the basis of disability:</td>
<td>who are receiving them to non-disabled persons</td>
<td></td>
</tr>
<tr>
<td>States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.</td>
<td>• based on health-services that are gender specific</td>
<td>Proportion of women receiving appropriate health care to the proportion of men</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• based on the same range, quality and standard of free and affordable health care and programmes</td>
<td>Proportion of children receiving early identification and intervention, to all children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• based on appropriate early identification and intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• based on access to health services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table one indicates the significance of noting down goals, targets, indicators, and data sources for the realization of the right to health.

A review of the right to health sections of state reports and concluding observations indicated that they were slightly vague and rather than provide recommendation on how to achieve social change, they merely exercised a role of warning.

Rather than it be the role of the UNCRPD Committee to develop targets and indicators, it is important that different countries make a commitment to health human rights develop targets and indicators taking into consideration the situation in the country. If presented well in state reports, concluding observation could approve or ask to modify targets. Further, it would
provide the UNCRPD committee information on the rate of progress. Though the role of the Committee is limited, the statement of progress can be encouraging and motivate further action towards implementing human rights in health. The UNCRPD Committee’s concluding observations could include recognition of a State Party in achieving health human rights and complying with international standards, and a ranking or qualitative comparison to other countries. This will also contribute to the data collection process by creating an incentive. Collecting data, setting goals and targets will enable the development of indicators and create a stronger monitoring process. Thus, maintaining the process of submitting state party reports and receiving concluding observations could be beneficial in the monitoring process of disability rights and deciphering how successful the convention has been in shaping social environments all over the world.

Despite guidance in literature on how frameworks and indicators can be developed to successfully implement human rights in health and medical programmes, they should be taken with caution due to limitations. The rate of progress and achievement of human rights in health care is not simple rather challenging on many levels. Firstly, the rate of change would be greater in resource-richer developed countries and less in resource-limited developing countries. Secondly, conflict could also occur in countries that are rich in resources. It is important to find a balance between governmental goals and international obligations; if dual conflict is not resolved then it will be difficult to achieve change. While indicators and frameworks should be developed for more efficient implementation of human rights in health care, a universal indicator cannot be developed. Due to variance in social environments frameworks cannot be generalised and each government would be responsible for creating their own indicators. A universal indicator would have to be general which could lead to inconsistencies in adoption across the globe, and thereby create a variety of standards.
in disability rights. The development of indicators and putting legislation into practice would require much work and dedication from not just governments and individuals in charge of changing laws but also social organisations. Thus the process of achieving social change will not simply occur from past learnings, but will require planning, and the collaboration and effort of organisations and groups whose interest it is to achieve human rights in healthcare.
References


