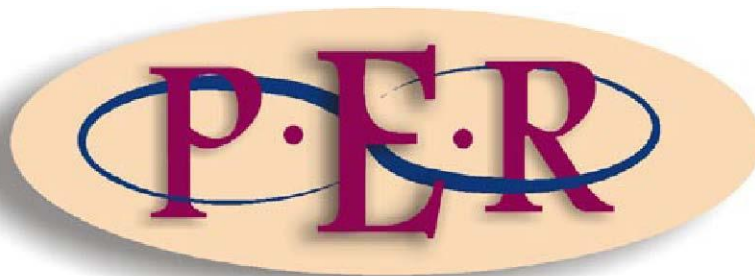


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EXPLORING THE CULTURAL DIMENSIONS OF THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

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1 Introduction

The right to the highest attainable standard of health, or simply the right to health, is incorporated in many international and regional human rights instruments. Health has been defined by the WHO in its Constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The right to health does not mean the right to be healthy. There are evidently non-medical factors and/or factors beyond the control of the State that influence one's health, including natural factors, education and income, as well as one's own behaviour. The right to health mainly implies that States should create conditions in which everyone can be as healthy as possible. This means that the right to health is more than merely the right to access health care and health goods and services. The right to health extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.¹

The right to health contains both freedoms and entitlements.² The freedoms include, for instance, the right to control one's own health and body, including sexual and reproductive freedom, as well as the right to be free from non-consensual medical treatment or experimentation.³ The entitlements broadly come down to "... the right

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¹ ESC Committee *General Comment No 14 on the Right to the Highest Attainable Standard of Health* (2000) (hereafter *General Comment No 14*) para 8.

² *General Comment No 14* para 8.

³ This is also laid down in a 7 of the *International Covenant on Civil and Political Rights* (1966): "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".⁴

Both aspects of the right to health – freedoms and entitlements – have important cultural dimensions.⁵ Health is not only a medical but also a cultural concept that relates to deeply held cultural values and ideas about life, death, disease, suffering and healing.⁶ The ways that individuals choose to use their freedom of health and body is largely determined by cultural considerations, including religious considerations. Cultural considerations and arguments play a particularly important role in the health area of sexual and reproductive behaviour. As regards the entitlements of the right to health, the cultural identity and integrity of the individuals and communities involved should be taken into account in providing health care, goods and services. Certain cultural communities may for instance prefer access to traditional preventive care, healing practices or medicines. The UN Committee on Economic, Social and Cultural Rights (hereafter the ESC Committee), the independent body supervising the implementation of the *International Covenant on Economic, Social and Cultural Rights*⁷ (hereafter the ICESCR) has recognized the cultural dimensions of the right to health. It has stated that the right to health implies that health facilities, goods and services must be culturally appropriate, in other words respectful of the culture of individuals and communities.⁸

At the same time, it should be noted that culture and health may have a problematic relationship. Cultural patterns, attitudes or stereotypes may severely limit the health freedoms of people or may prevent certain people from accessing health care. Furthermore, there are cultural or traditional practices that are condoned and that are very harmful to people's health.⁹ Two other UN Committees, the Committee on

⁴ *General Comment No 14* para 8.

⁵ For a general analysis of the cultural dimension of international human rights, see Vrdoljak *Cultural Dimension of Human Rights*.

⁶ De Castro 1997 *Bioethics* 193-195.

⁷ *International Covenant on Economic, Social and Cultural Rights* (1966).

⁸ *General Comment No 14* para 12c.

⁹ According to a UN Factsheet, harmful traditional practices include "... female genital mutilation (FGM); forced feeding of women; early marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son

the Elimination of All Forms of Discrimination Against Women (hereafter the CEDAW Committee) and the Committee on the Rights of the Child (hereafter the CRC Committee) have in a joint General Recommendation stated that sex- and gender-based stereotypes, inequalities and discrimination, as well as harmful traditional practices such as female genital mutilation, forced marriages, polygamy and crimes in the name of honour, have a negative impact on the health of people and should be combatted by States.¹⁰

In other words, it seems that international human rights law demands respect for the cultural dimensions of the right to health, while at the same time requiring the protection of the right to health against negative aspects of cultures. How does this work out in practice? What does the concept of "culturally appropriate" health goods and services mean at the national or local level? Who decides on what is or is not culturally appropriate? Another, broader question is to what extent such respect for cultural diversity can be reconciled with the universality of the right to health. In recent years it has been acknowledged that the universal value and application of international human rights does not imply the uniform implementation of these rights.¹¹ In relation to the right to health, it is universally accepted, irrespective of culture, that all people everywhere have a right to health and that States are obliged to provide health care and to protect people from threats to their health. At the same time, it is clear that the right to health cannot and does not have to be implemented in the same way universally, because States are very diverse in terms of their available resources, as well as their cultural, social and historical backgrounds.¹²

preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price". (OHCHR date unknown <http://goo.gl/hhSgKk>).

¹⁰ CEDAW Committee and CRC Committee *Joint General Recommendation / General Comment No 31 of the Committee on the Elimination of Discrimination against Women and General Comment No 18 of the Committee on the Rights of the Child on Harmful Practices* (2014) (hereafter *Joint General Recommendation No 31/No 18*).

¹¹ Advisory Council on International Affairs *Universality of Human Rights*; Donders 2010 *Int Soc Sci J* 15-35; Donnelly 2007 *Hum Rts Q* 281-306; Brems 2004 *Human Rights Review* 5-21; Sajo *Human Rights with Modesty*; Petersen 2011 *Asian JIL* 149-163; Kinley "Bendable Rules" 50-65.

¹² Tobin *Right to Health* 68.

The implementation of the right to health accordingly allows for variety in laws, policies and measures, taking into account the local context and circumstances. The margin of discretion left to States to pursue a context-sensitive implementation of the right to health is not absolute, however. The accommodation of cultural differences in relation to the right to health, as well as the protection of the right to health against obstacles to its enjoyment, is subject to international supervision. How have international supervisory bodies precisely dealt with the various cultural dimensions of the right to health? How have they elaborated on and interpreted the freedoms and entitlements of the right to health of individuals and the obligations of States Parties arising from the treaties in this regard?

This article explores the cultural dimensions of the normative content of the right to health.¹³ It analyses several treaty provisions and in particular the interpretation of these provisions by the treaty monitoring bodies. Apart from several UN treaties, notably the ICESCR, the article also addresses several regional treaties in Africa, notably the African Charter on Human and Peoples' Rights.¹⁴ Many African States have vast problems in protecting the right to health because of severe health challenges, such as weak and fragmented health systems; inadequate resources; the burden of infectious diseases, recurrent natural and manmade disasters and emergencies; and extreme poverty.¹⁵ Some of these challenges are linked to the cultural dimensions of the right to health. It may further be interesting to see to what extent the monitoring of the right to health at regional level, compared to the universal level, provides different or more precise insights into its cultural dimensions.

¹³ For detailed elaborative work on the right to health, see *inter alia* Tobin *Right to Health*; Toebes *et al Health and Human Rights*; Toebes *Right to Health*; Chapman "Core Obligations". Also see the work of the UN Special Rapporteur on the Right to Health (OHCHR 2015 <http://goo.gl/alggMk>) as well as the work done by the World Health Organization (WHO) (WHO 2015 <http://www.who.org>).

¹⁴ *African Charter on Human and Peoples' Rights* (1981).

¹⁵ WHO Regional Office for Africa *Health of the People* xxiii.

2 The right to health in UN human rights treaties

The right to the highest attainable standard of health is included in several universal human rights instruments. The most comprehensive provision on the right to health is included in Article 12 of the ICESCR. This provision reads as follows:

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.

The right to health is also included in human rights instruments for specific groups, often referred to as vulnerable or disadvantaged groups, such as women, children, minorities and indigenous peoples.

Article 12 of the *Convention on the Elimination of All Forms of Discrimination Against Women*¹⁶ (hereafter the CEDAW) promotes the elimination of discrimination against women in the field of health and equal access to health care services, including those related to family planning. Special attention is paid to providing appropriate services in relation to pregnancy, confinement and the post-natal period. The CEDAW also contains a specific provision on the elimination of stereotypes and prejudices regarding women that may impede their rights, including their right to health. Article 5(a) provides that States Parties shall take all appropriate measures

... to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

The right to the highest attainable standard of health and to access facilities for the treatment of illness and the rehabilitation of health is also included in Article 24 of

¹⁶ *Convention on the Elimination of All Forms of Discrimination Against Women* (1979).

the *Convention on the Rights of the Child*¹⁷ (hereafter the CRC). According to the CRC, States Parties shall strive to ensure that no child is deprived of his or her right of access to health care services. Article 24(3) of the CRC also includes the statement that

... States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

Although "traditional practices" are not defined, it has become clear from the drafting process that this provision was meant to combat female genital mutilation (hereafter FGM).¹⁸

Other UN human rights treaties also include the right to the highest attainable standard of health, for instance in Article 28 of the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*¹⁹ and Article 25 of the *Convention on the Rights of Persons with Disabilities*.²⁰

The *Declaration on the Rights of Indigenous Peoples*²¹ includes in Article 24 the right to the highest attainable standard of physical and mental health and of access without discrimination to social and health services. One of the cultural dimensions is recognised in the first paragraph of this provision, which gives indigenous peoples the right

... to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.

The right to health has been firmly incorporated in universal human rights instruments. Some of the provisions in these instruments also address the cultural dimensions of the right to health. These have been elaborated upon further by the treaty monitoring bodies.

¹⁷ *Convention on the Rights of the Child* (1989).

¹⁸ Harris-Short 2003 *Hum Rts Q* 136-137.

¹⁹ *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (1990).

²⁰ *Convention on the Rights of Persons with Disabilities* (2006).

²¹ *Declaration on the Rights of Indigenous Peoples* (2007).

3 Monitoring by UN treaty bodies

Each of the UN human rights treaties has a monitoring body composed of independent experts which supervises the implementation of the treaties in the national legal orders of States Parties and their compliance with their international treaty obligations. The treaty monitoring bodies have two procedures at their disposal: the periodic State reporting procedure and the individual communications procedure. The reporting procedure is compulsory for each State Party and implies that it has to report to the treaty body in question on how it has implemented the treaty. The treaty bodies then enter into a dialogue with the State Party in writing and in an oral session. Finally, they adopt so-called Concluding Observations in which they outline the positive developments and remaining challenges, as well as their concerns as regards the implementation of the treaty concerned. The Concluding Observations have the legal status of recommendations and are therefore not legally binding.

The individual communications procedures are not compulsory under the treaties themselves. States need to specifically accept the competence of the treaty bodies to deal with individual complaints via the ratification of an Optional Protocol or by submitting a specific declaration. If this is done, individuals are allowed to submit a communication to the treaty body on alleged violations of the treaty, after national remedies are exhausted. The whole procedure is written and confidential; no oral hearings take place. The treaty bodies finally present their Views or Opinions on the case, concluding whether the State has complied with or violated the treaty. The Views and Opinions are not legally binding.

Treaty bodies also adopt so-called General Comments or General Recommendations in which they comment on specific treaty provisions or elaborate on the relationship between the treaty and specific themes or issues. These General Comments reflect the experience of the treaty bodies gained from the reporting and complaints

procedures. General Comments and Recommendations are not legally binding, but they provide an authoritative interpretation of the treaty in question.²²

The practice of various treaty monitoring bodies is analysed below to see how they have elaborated on the cultural dimensions of the right to health.

3.1 General comments and recommendations

As indicated in the introduction, the ESC Committee has explicitly recognised one of the cultural dimensions of the right to health. In its General Comment on Article 12 of the ICESCR it has described the different interrelated elements of the right to health, namely accessibility, availability, acceptability and quality, "...the precise application of which will depend on the conditions prevailing in a particular State party".²³ Acceptability, according to the Committee, means that

... all health facilities, goods and services must be ... culturally appropriate, *i.e.*, respectful of the culture of individuals, minorities, peoples and communities ...²⁴

Under quality, the Committee has reiterated the dimension of cultural acceptability by stating that

... as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.²⁵

The Committee has further reaffirmed that one of the State obligations in relation to the right to health is to ensure that health services are culturally appropriate and that health care staff are trained to recognise and respond to the specific needs of vulnerable or marginalised groups.²⁶

In its General Comment on the right to take part in cultural life, the ESC Committee has further elaborated on the concept of cultural appropriateness, by stating that

[A]ppropriateness refers to the realization of a specific human right in a way that is pertinent and suitable to a given cultural modality or context, that is, respectful of the culture and cultural rights of individuals and communities, including minorities

²² Alston and Goodman *International Human Rights* 791-794.

²³ *General Comment No 14* para 12.

²⁴ *General Comment No 14* para 12c.

²⁵ *General Comment No.14* para 12d.

²⁶ *General Comment No 14* para 37.

and indigenous peoples... The way in which rights are implemented may also have an impact on cultural life and cultural diversity.²⁷

In this General Comment, the Committee has generally urged States Parties to take into account cultural values attached to the way health and education services are provided.²⁸

The ESC Committee has further noted the special position of certain (groups of) subjects of the right to health, such as women, children, adolescents and indigenous peoples. These groups may need special measures of protection to ensure that they have equal access to health goods and services. Such measures can be envisaged to meet the specific *cultural* needs or preferences in relation to health goods and services. At the same time, special measures may be needed to remove cultural barriers to accessing health goods and services or to protect people from cultural practices that are harmful to their health. Both aspects are addressed by the ESC Committee in its General Comment on the right to health.

In relation to indigenous peoples, for instance, the ESC Committee has noted that in ensuring that health services are culturally appropriate, account should be taken of traditional preventive care, healing practices and medicines. The ESC Committee has further stated that:

States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health.²⁹

The ESC Committee has also recognised the crucial cultural relationship between indigenous peoples and their land, including the role of land in relation to health. It has urged States Parties to protect vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples. It has also warned that the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking

²⁷ ESC Committee *General Comment No 21 on the Right of Everyone to Take Part in Cultural Life* (2009) (hereafter *General Comment No 21*) para 16(e).

²⁸ *General Comment No 21* para 16(e).

²⁹ *General Comment No.14* para 27.

their symbiotic relationship with their lands, has a deleterious effect on their health.³⁰

In relation to women, the ESC Committee has acknowledged their vulnerability to harmful traditional and/or cultural practices, in particular in relation to sexual and reproductive rights. It has urged States Parties to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.³¹ The ESC Committee has maintained that the failure to discourage the continued observance of harmful traditional medical or cultural practices is a violation of the obligation to protect.³²

The CEDAW Committee has noticeably also addressed the obstacles that women face to their enjoyment of the right to health, in particular in relation to sexual and reproductive health. Violations of women's right to health, such as a lack of access to health goods and services, are often justified by references to culture or religion, or they are caused by persistent cultural patterns, stereotypes or cultural practices, as addressed by Article 5 of the CEDAW. The CEDAW Committee specified in its General Recommendation on the right to health that this right implies that States Parties should assess the health status and needs of women and "... take into account any ethnic, regional or community variations or practices based on religion, tradition or culture".³³

States Parties should furthermore show how they address specific factors in relation to health goods and services, which differ for women in comparison with men. These factors not only include biological ones, but also socio-economic factors, including cultural or traditional practices, in particular FGM.³⁴ The CEDAW Committee also adopted a General Recommendation specifically on FGM, in which it recommended that States Parties "... take appropriate and effective measures with a view to

³⁰ *General Comment No 14* para 27.

³¹ *General Comment No 14* para 21.

³² *General Comment No 14* para 51.

³³ CEDAW Committee *General Recommendation No 24: Article 12 of the Convention (Women and Health)* (1999) (hereafter *General Recommendation No 24*) para 9.

³⁴ *General Recommendation No 24* para 12.

eradicating the practice of female circumcision".³⁵

Examples of such measures were the collection of data about these and other practices harmful to women, support for organisations working for the elimination of these practices, and the introduction of educational programmes about the problems arising from FGM.³⁶

The CRC Committee has also addressed the different cultural dimensions of the right to health. In its General Comment on adolescent health and development, the CRC Committee followed the ESC Committee in identifying as one of the characteristics of the right to health for adolescents that it should be acceptable, meaning that

... all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live.³⁷

Apart from the accommodation of specific cultural needs in relation to the right to health, the CRC Committee has also addressed the protection of the right to health against cultural practices and the removal of obstacles to its enjoyment. In this General Comment it indicated, for instance, that in relation to the problem of sexually transmitted diseases, including HIV and AIDS, States Parties should take measures aimed at changing cultural views about adolescents' need for contraception. States Parties should also address cultural and other taboos surrounding adolescent sexuality.³⁸ The CRC Committee has further called upon States Parties to protect adolescents from harmful traditional practices, mentioning early marriages, honour killings and female genital mutilation as examples.³⁹

In its General Comment on violence against children, the CRC Committee identified the presence of widespread cultural and social attitudes and practices that condone

³⁵ CEDAW Committee *General Recommendation No 14: Female Circumcision* (1990) (hereafter *General Recommendation No 14*) para a.

³⁶ *General Recommendation No 14* ss i, ii, iii, iv.

³⁷ CRC Committee *General Comment No 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child* (2003) (hereafter *General Comment No 4*) para 41(c).

³⁸ *General Comment No 4* para 30.

³⁹ CRC Committee *General Comment No 8 on the Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (2007) (hereafter *General Comment No 8*) para 39(g).

violence and the need for a holistic approach to combat these.⁴⁰ The CRC Committee also adopted a General Comment on indigenous children in which it emphasised their rights to enjoy their own culture. It urged States Parties to take special measures to ensure that indigenous children "...have access to culturally appropriate services in the areas of health..."⁴¹ It has also noted that States Parties should work to ensure that "...health-care services are culturally sensitive and that information about these is available in indigenous languages."⁴² Special attention has been paid to the role of traditional medicine and health care workers. According to the CRC Committee, preference should be given to the employment of local, indigenous community workers, and they should be provided with the necessary means and training "in order to enable that conventional medicine be used by indigenous communities in a way that is mindful of their culture and traditions".⁴³

At the same time, the CRC Committee has maintained that harmful practices, mentioning early marriages and female genital mutilation, should be eradicated.⁴⁴

In the light of the fact that both the women's rights convention and the children's rights convention contain legally binding obligations concerning the elimination of harmful practices, the CEDAW Committee and the CRC Committee adopted a joint General Recommendation on this issue, including its link with health.⁴⁵ In the Recommendation they once again stressed the obligations of States to eradicate harmful practices, mentioning specifically FGM, child and/or forced marriages, polygamy and crimes committed in the name of so-called honour. The obligations of States Parties include not only the adoption of legislation, but also broader measures including data collection and monitoring, preventive measures and educational measures.

⁴⁰ CRC Committee *General Comment No 13 on the Right of the Child to Freedom from all Forms of Violence* (2011) (hereafter *General Comment No 13*) paras 12, 45.

⁴¹ CRC Committee *General Comment No 11 on Indigenous Children and Their Rights under the Convention* (2009) (hereafter *General Comment No 11*) paras 25, 50.

⁴² *General Comment No 11* para 51.

⁴³ *General Comment No 11* para 52.

⁴⁴ *General Comment No 11* para 22.

⁴⁵ *Joint General Recommendation No 31/No 18*.

From the above it can be concluded that the different cultural dimensions of the right to health as incorporated in international treaties are broadly recognised by the treaty monitoring bodies. There are, broadly speaking, two sorts of cultural dimensions. Firstly, there is the promotion of the cultural dimensions of the right to health, reflected in the concepts of the cultural appropriateness or cultural sensitivity of health goods and services. This implies that the proper promotion and protection of the right to health requires that health goods and services are respectful of cultural differences and that traditional treatment and medication are respected and protected. Secondly, there is the protection of the right to health against certain cultural approaches or practices. This implies that the proper promotion and protection of the right to health requires that cultural patterns and stereotypes that form an obstacle to the enjoyment of the right to health and cultural practices that are harmful to health should be eradicated.

3.2 *Concluding Observations*

The different cultural dimensions of the right to health have also been addressed by the treaty monitoring bodies in their Concluding Observations on State reports. For this article, the Concluding Observations of the ESC Committee, the CEDAW Committee and the CRC Committee, as adopted in the period of 2008-2014, were studied, using the key words of health, culture, tradition and religion.⁴⁶ The analysis firstly shows that, despite the explicit attention given to culture and health in the General Comments and Recommendations as discussed above, the cultural dimensions of the right to health are not often nor consistently addressed in the Concluding Observations. Explicit references to the cultural appropriateness of health goods and services, for instance, were scarcely found. Much more attention was paid to the eradication of cultural patterns and stereotypes, as well as cultural practices that impede the enjoyment of the right to health.

⁴⁶ The individual complaint procedures of the ICESCR and the CRC have only recently entered into force and the Committees have not yet dealt with individual cases; the views on individual complaints adopted by the CEDAW Committee until 2014 did not explicitly address the cultural dimension of the right to health.

The instances where the cultural dimensions of the right to health were addressed show a large variety of situations. They are discussed below under three headings representing three types of State obligations, realising that these often overlap: 1) to ensure equal access to health goods and services, if need be by implementing special measures for certain cultural communities, such as minorities and indigenous peoples; 2) to respect and protect culture-specific health goods and services, including traditional treatments and medicines, in particular of indigenous peoples; 3) to combat stereotypes and eradicate harmful cultural practices that impede the right to health.

3.2.1 Special measures to ensure equal access to health goods and services

General equal access to health goods and services is often discussed in the evaluation of the State reports under the ICESCR. Sometimes States Parties are encouraged to improve access for certain cultural groups and communities, including indigenous peoples⁴⁷, minorities⁴⁸, Roma⁴⁹ and immigrants,⁵⁰ whereby the specific cultural or religious needs of these groups are addressed. For instance in the case of Afghanistan, the ESC Committee noted with concern the failure of the health system to respond adequately to the needs of women, and the lack of a gender-sensitive approach in health services. The ESC Committee further noted that harmful practices and barriers had detrimental impact on the women's health, giving as an example the fact that women cannot be examined by a male doctor without a chaperone. It

⁴⁷ See, for instance, the Concluding Observations of the ESC Committee on Bolivia (E/C.12/BOL/CO/2 8 August 2008) para 15; Nicaragua (E/C.12/NIC/CO/4 28 November 2008) para 11; Chile (E/C.12/1/Add.105 1 December 2004) para 34; Colombia (E/C.12/COL/CO/5 7 June 2010) para 25; and Guatemala (E/C.12/GTM/CO/3 9 November 2014) paras 11, 22.

⁴⁸ See, for instance, the Concluding Observations by the ESC Committee on Macedonia (E/C.12/MKD/CO/1 15 January 2008) para 32; Israel (E/C.12/1/Add.27 4 December 1998) para 10; Montenegro (E/C.12/MNE/CO/1 15 December 2014) paras 10, 23; Serbia (E/C.12/SRB/CO/2 10 July 2014) para 11.

⁴⁹ ESC Committee, Concluding Observations Greece (E/C.12/1/Add.97 7 June 2004) para 11; Slovakia (E/C.12/SVK/CO/2 8 June 2012) para 9; Finland (E/C.12/FIN/CO/6 17 December 2014) para 12; Portugal (E/C.12/PRT/CO/4 8 December 2014) para 7; Romania (E/C.12/ROU/CO/3-5 9 December 2014) para 9; Slovenia (E/C.12/SVN/CO/2 15 December 2014) para 11; Czech Republic (E/C.12/CZE/CO/2 23 June 2014) para 9; Lithuania (E/C.12/LTU/CO/2 24 June 2014) para 7; Ukraine (E/C.12/UKR/CO/6 13 June 2014) para 8.

⁵⁰ ESC Committee, Concluding Observations Spain (E/C.12/ESP/CO/5 6 June 2012) para 19; Finland (E/C.12/FIN/CO/6 17 December 2014) para 27; Czech Republic (E/C.12/CZE/CO/2 23 June 2014) para 15.

urged the State Party to increase, through more training and more active recruitment, the number of female medical staff, in particular midwives and gynaecologists.⁵¹ The ESC Committee also urged Indonesia to remove cultural barriers and to ensure access to sexual and reproductive health services to "unmarried women and teenagers as well as to married women without the consent of spouses".⁵² In relation to Indonesia the Committee used the notion of cultural appropriateness in relation to mental health services, recommending that the State Party prioritise "the development of culturally appropriate community-based care of persons with psychosocial disabilities".⁵³ In relation to Romania the ESC Committee noted with concern the use of conscientious objection by medical staff in order not to carry out certain health services, such as abortion.⁵⁴

Equal access to health goods and services is discussed in almost every report under the CEDAW, showing that in many countries women lack such access. The CEDAW Committee has frequently urged States Parties to create a gender sensitive health care system, to provide women with equal access to health goods and services and to remove cultural, religious and linguistic barriers that prevent or obstruct such access. Linguistic barriers were noted in Finland, for instance, where the Committee found that hospitals and clinics rarely provide services in the Sami language.⁵⁵ Cultural and religious barriers are of particular concern in relation to access to sexual and reproductive health care. The CEDAW Committee often urges States to raise awareness to eliminate cultural beliefs that impede women's free access for instance to family planning services and contraceptive methods.⁵⁶ The CEDAW Committee has paid special attention to women belonging to indigenous peoples or national, ethnic, linguistic or religious minorities, as well as Roma, who may suffer double or multiple

⁵¹ ESC Committee Concluding Observations Afghanistan (E/C.12/AFG/CO/2-4 21 May 2010) para 40.

⁵² ESC Committee Concluding Observations Indonesia (E/C.12/IDN/CO/1 19 June 2014) para 33.

⁵³ ESC Committee Concluding Observations Indonesia (E/C.12/IDN/CO/1 19 June 2014) para 34.

⁵⁴ ESC Committee Concluding Observations Romania (E/C.12/ROU/CO/3-5 9 December 2014) para 22.

⁵⁵ CEDAW Committee, Concluding Observations Finland (CEDAW/C/FIN/CO/7 10 March 2014) para 36.

⁵⁶ CEDAW Committee, Concluding Observations Iraq (CEDAW/C/IRQ/CO/4-6 10 March 2014) para 42.

discrimination.⁵⁷ Migrant women have also been mentioned.⁵⁸ Sometimes, for instance in relation to Peru, the Committee commended the inclusion of an "intercultural perspective" in access to sexual and reproductive health, but still recommended that the State Party eliminate cultural and other barriers faced by women in gaining access to health services, and strengthen its "intercultural approach" to the provision of health services.⁵⁹ In the case of Belgium the CEDAW Committee expressed concerns at the possible impact of the ban on wearing headscarves in public hospitals on access to these institutions and asked the State Party to monitor that.⁶⁰ The CEDAW Committee also expressed its concern about the excessive or abusive use of the conscientious objection clause by medical personnel in order not to carry out abortions.⁶¹

The Concluding Observations of the CRC Committee also frequently deal with general access to health goods and services, recommending States Parties to improve overall access and access for certain groups of children, such as those living in rural and remote areas⁶² and those belonging to minorities and indigenous

⁵⁷ See, for instance, the Concluding Observations by the CEDAW Committee on Ecuador (CEDAW/C/ECU/CO/7 7 November 2008) para 25; New Zealand (CEDAW/C/NZL/CO/6 10 August 2007) paras 38-39; Honduras (CEDAW/C/HON/CO/6 26 July 2007) paras 24-25; Turkmenistan (CEDAW/C/TKM/CO/2 2 June 2006) paras 28-29; Australia (CEDAW/C/AUL/CO/5 3 February 2006) para 28; Guatemala, (CEDAW/C/GUA/CO/6 2 June 2006) para 36; Philippines (CEDAW/C/PHI/CO/6 15 August 2006) para 29; Venezuela (CEDAW/C/VEN/CO/6 31 January 2006) para 32; Cambodia (CEDAW/C/KHM/CO/3 25 January 2006) para 36; China (CEDAW/C/CHN/CO/6 25 August 2006) para 16; India (CEDAW/C/IND/CO/3 2 February 2007) para 40; Israel (CEDAW/C/ISR/CO/5 4 February 2011) paras 38-39; Czech Republic (CEDAW/C/CZE/CO/3 24 August 2006) para 22; Romania (CEDAW/C/ROM/CO/6 2 June 2006) paras 26-27; Namibia (CEDAW/C/NAM/CO/3 2 February 2007) paras 26-27; Greece (CEDAW/C/GRC/CO/6 2 February 2007) paras 17-18; Albania (CEDAW/C/ALB/CO/3 16 September 2010) para 35; FYRM (CEDAW/C/MKD/CO/3 3 February 2006) para 27; China (CEDAW/C/CHN/CO/7-8 7 November 2014) para 46; Georgia (CEDAW/C/GEO/CO/4-5 24 July 2014) paras 34, 35; India (CEDAW/C/IND/CO/4-5 24 July 2014) paras 34, 35; Qatar (CEDAW/C/QAT/CO/1 10 March 2014) para 39.

⁵⁸ See, for instance, the Concluding Observations by the CEDAW Committee on Austria (CEDAW/C/AUT/CO/6 2 February 2007) paras 29-30; Germany (CEDAW/C/DEU/CO/6 10 February 2009) paras 53-54; Belarus (CEDAW/C/BLR/CO/7 4 February 2011) para 36; The Netherlands (CEDAW/C/NLD/CO/4 2 February 2007) para 27.

⁵⁹ CEDAW Committee, Concluding Observations Peru (CEDAW/C/PER/CO/7-8 24 July 2014) paras 33, 34.

⁶⁰ CEDAW Committee, Concluding Observations Belgium (CEDAW/C/BEL/CO/7 14 November 2014) paras 18, 19.

⁶¹ CEDAW Committee, Concluding Observations Poland (CEDAW/C/POL/CO/7-8, 14 November 2014) paras 36, 37; Peru (CEDAW/C/PER/CO/7-8 24 July 2014) para 25.

⁶² See, for instance the Concluding Observations by CRC Committee on Mozambique (CRC/C/MOZ/CO/2 4 November 2009) paras 29, 61; Sudan (CRC/C/SDN/CO/3-4 22 October

peoples and Roma.⁶³ In some cases the CRC Committee notes with concern the underlying cultural beliefs, traditions or stereotypes that sustain discrimination.⁶⁴ For instance in the case of Niger the CRC Committee expressed particular concern at the traditional or religious beliefs that limit children's access to health care, and it called upon the State Party to increase its efforts to ensure equal access to quality health services by all children.⁶⁵

3.2.2 Respect for and protection of culture-specific health goods and services

The ESC Committee on several occasions has urged States Parties to recognise and protect culture-specific health goods and services, most notably traditional medicines in relation to indigenous peoples. Bolivia, for instance, was praised for its efforts to include traditional medicine in the National Health Plan.⁶⁶ At the same time the ESC Committee recommended that Bolivia develop a special intellectual property regime protecting the collective rights of the indigenous peoples, including their traditional knowledge and traditional medicine.⁶⁷ In the case of Australia the ESC Committee encouraged the State Party to guarantee the consultation of indigenous peoples in order to harness the potential of their traditional knowledge and culture.⁶⁸ As regards Chile, the ESC Committee urged the State to strengthen efforts to recover indigenous lands.⁶⁹

The CEDAW Committee and the CRC Committee do not often include a reference to culture-specific health goods and services in their Concluding Observations. They

2010) paras 50-51; Mauritania (CRC/C/MRT/CO/2 June 2009) paras 55-56; Angola (CRC/C/AGO/CO/2 4 October 2010) paras 49-50; Tunisia (CRC/C/TUN/CO/3 16 June 2010) paras 51-52; Russian Federation (CRC/C/RUS/CO/4-5 25 February 2014) paras 63, 64 .

⁶³ See, for instance the Concluding Observations by the CRC Committee on Bolivia (CRC/C/BOL/CO/4 16 October 2009) para 28, 76, 85; Cambodia (CRC/C/KHM/CO/2-3 20 June 2011) para 28; Republic of Moldova (CRC/C/MDA/CO/3 20 February 2009) para 25; Bulgaria (CRC/C/BGR/CO/2 23 June 2008) paras 46, 71; Congo (CRC/C/COG/CO/2-4 25 February 2014) paras 72, 73; Portugal (CRC/C/PRT/CO/3-4 25 February 2014) paras 25, 26; India (CRC/C/IND/CO/3-4 7 July 2014) paras 32, 79; Indonesia (CRC/C/IDN/CO/3-4 10 July 2014) para 70; Hungary (CRC/C/HUN/CO/3-5 14 October 2014) paras 46, 47.

⁶⁴ CRC Committee, Concluding Observations Indonesia (CRC/C/IDN/CO/3-4 10 July 2014) para 20.

⁶⁵ Concluding Observations on Niger (CRC/C/NER/CO/2 18 June 2009) paras 55-56.

⁶⁶ ESC Committee, Concluding Observations Bolivia (E/C.12/BOL/CO/2 8 August 2008) para 21.

⁶⁷ ESC Committee, Concluding Observations Bolivia (E/C.12/BOL/CO/2 8 August 2008) para 37.

⁶⁸ ESC Committee, Concluding Observations Australia (E/C.12/AUS/CO/4 12 June 2009) para 27.

⁶⁹ ESC Committee, Concluding Observations Chile (E/C.12/1/Add.105 26 November 2004) para 34.

sometimes make a general reference to the cultural dimensions of the right to health, combining access and culturally appropriate health goods and services. For instance, in the case of Ecuador the CEDAW Committee recommended that the State take measures "to ensure that all women have easy access to health services that are culturally sensitive and of good quality".⁷⁰ It did not specify what "culturally sensitive" precisely means and who should decide on what is or is not culturally sensitive.

The CRC Committee recommended in the case of the Philippines that the State should implement policies and programmes to ensure equal access for indigenous and minority children to culturally appropriate health services.⁷¹ The CRC Committee further recommended that Nicaragua ensure access to culturally-sensitive health care for all children, specifically mentioning protection of the rights of indigenous and Afro-descendant children with regard to their culture and language, "particularly in the provision of access to basic services, and by promoting culturally- and linguistically-sensitive ... health policies and programmes".⁷²

Similar recommendations were made to Guatemala.⁷³ In the case of Mozambique, the CRC Committee recommended the State Party to develop culturally sensitive health-care services for pregnant women.⁷⁴ No further specification has been given of what "culturally sensitive" or "culturally-appropriate" means in practice and to what extent these are similar concepts. While both concepts demand respect for and the taking into account of cultural differences, "cultural appropriateness" may seem to imply more concrete results. It further remains unclear who determines what is or is not "culturally appropriate". Treaty bodies leave this to the States Parties, but they also demand input from and cooperation with the cultural communities concerned,

⁷⁰ CEDAW Committee, Concluding Observations Ecuador (CEDAW/C/ECU/CO/7 7 November 2008) para 39.

⁷¹ CRC Committee, Concluding Observations the Philippines (CRC/C/PHL/CO/3-4 2 October 2009) para 84.

⁷² CRC Committee, Concluding Observations Nicaragua (CRC/C/NIC/CO/4 1 October 2010) paras 63, 84.

⁷³ CRC Committee, Concluding Observations Guatemala (CRC/C/GTM/CO/3-4 25 October 2010) para 71.

⁷⁴ CRC Committee, Concluding Observations Mozambique (CRC/C/MOZ/CO/2 4 November 2009) para 62(e).

although without clear instructions.

3.2.3 Combat harmful traditional and cultural practices

Most addressed in the Concluding Observations are the negative aspects of culture in relation to the right to health. Much attention is paid to cultural patterns and stereotypes that form an impediment to the equal enjoyment of the right to health, and harmful cultural practices that have a negative impact on health. States Parties are strongly encouraged not to allow or condone but to eradicate cultural practices that are detrimental to the right to health. FGM is time and again singled out in this respect, for instance in relation to Gambia⁷⁵, Nigeria⁷⁶, Guinea⁷⁷ and Mali.⁷⁸ The ESC Committee considers FGM "a practice which is incompatible with the human rights of women and in particular with the right to health".⁷⁹ It therefore urges States to eradicate this practice, for instance by conducting "culturally sensitive education campaigns against FGM."⁸⁰

The ESC Committee has further expressed its concern about the prevailing phenomenon of early and forced marriages in several States Parties, which it considers to have negative impacts on the right to health, in particular reproductive rights.⁸¹ In the case of India, for instance, it argued that this practice could be attributed largely to the lack of sex and reproductive education, which is still viewed to be taboo in India.⁸² Early marriages were also discussed with Sri Lanka, where the ESC Committee noted that although the age for marriage in statutory law is 18 years old, girls as young as 12 years are able to marry under customary law, as long as the parents give their consent.⁸³ The ESC Committee further expressed concern about the situation in Nepal, where traditional attitudes among some castes and

⁷⁵ ESC Committee, Concluding Observations Gambia (E/C.12/1994/9 31 May 1994) para 16.

⁷⁶ ESC Committee, Concluding Observations Nigeria (E/C.12/1/Add.23 16 June 1998) para 20.

⁷⁷ ESC Committee, Concluding Observations Guinea (E/C.12/1/Add.5 28 May 1996) para 22.

⁷⁸ ESC Committee, Concluding Observations Mali (E/C.12/1994/17 21 December 1994) para 14.

⁷⁹ ESC Committee, Concluding Observations Nigeria (E/C.12/1/Add.23 16 June 1998) para 20.

⁸⁰ ESC Committee, Concluding Observations Indonesia (E/C.12/IDN/CO/1 19 June 2014) para 25.

⁸¹ ESC Committee, Concluding Observations Kyrgyzstan (E/C.12/1/Add.49 1 September 2000) para 23; Nepal (E/C.12/NPL/CO/3 12 December 2014) para 14; Uzbekistan (E/C.12/UZB/CO/2 13 June 2014) para 17.

⁸² ESC Committee, Concluding Observations India (E/C.12/IND/CO/5 8 August 2008) para 37.

⁸³ ESC Committee, Concluding Observations Sri Lanka (E/C.12/1/Add.24 16 June 1998) para 9.

ethnic groups contribute to the reproductive health problems of women.⁸⁴ Sex-selective abortions are also a practice condemned by the ESC Committee. For instance, Armenia was urged to address practices and social norms fuelling a preference for sons in order to fight sex-selective abortions.⁸⁵

The ESC Committee has further criticised the fact that some States Parties use religion or culture as a pretext *not* to implement certain provisions of the Covenant. In the case of Iran, for instance, the Committee observed that the Constitution of Iran subjects the enjoyment of many rights to restrictions such as "provided it is not against Islam" or "with due regard to Islamic standards". The Committee argued that such restrictive clauses negatively affect the application of the Covenant, including the right to health.⁸⁶

The CEDAW Committee, referring *inter alia* to Article 5 of its treaty, has on many occasions dealt with issues of social and cultural patterns, prejudices and harmful practices that impede the right to health or equal access to health goods and services. The CEDAW Committee has often criticised patriarchal societies in which men dominate women in areas of health and has urged States Parties to change these patterns that prevent women from enjoying their rights. For instance, in the case of Zambia the CEDAW Committee expressed its concern about the persistence of "unequal power relations between women and men and the inferior status of women and girls", which negatively affected their health situation.⁸⁷ The CEDAW Committee also expressed its concerns about the deep-rooted stereotypes regarding the roles and responsibilities of women and men in all spheres of life in Ethiopia and Ghana. It was concerned that such customs and practices perpetuated discrimination against women and continued women's disadvantageous and unequal status in sexual and reproductive health.⁸⁸ The Committee expressed similar concerns as regards Kenya, where it argued that gender-specific norms and the persistence of

⁸⁴ ESC Committee, Concluding Observations Nepal (E/C.12/NPL/CO/2 16 January 2008) para 26.

⁸⁵ ESC Committee, Concluding Observations Armenia (E/C.12/ARM/CO/2-3 16 July 2014) para 22.

⁸⁶ ESC Committee, Concluding Observations Iran (E/C.12/1993/7 9 June 1993) para 4.

⁸⁷ CEDAW Committee, Concluding Observations Zambia (CEDAW /C/ZMB/CO/5-6 29 July 2011) para 35.

⁸⁸ CEDAW Committee, Concluding Observations Ethiopia (CEDAW /C/ETH/CO/6-7 29 July 2011) para 18; Ghana (CEDAW/C/GHA/CO/6-7 7 November 2014) paras 22, 23.

unequal power relations between women and men and the inferior status of women and girls hampered their ability to negotiate safe sexual practices and consequently made them more vulnerable to infection with HIV/AIDS.⁸⁹ The Committee also urged Chad to tackle obstacles to women's access to health care, including socio-cultural norms.⁹⁰

Similar concerns were expressed in relation to other States Parties. In relation to Afghanistan, the CEDAW Committee noted its concern about

... deep patriarchal attitudes and cultural beliefs which limit women's freedom of movement and prevent them from being treated by male doctors and that women's access to contraceptives is subject to their husbands' authorization.⁹¹

It therefore urged the State Party to "conduct awareness raising campaigns to eliminate patriarchal attitudes and cultural beliefs which impede women's free access to health services and contraceptive methods".⁹²

In the case of Paraguay and Costa Rica, the CEDAW Committee expressed its concern about

... the persistence of discriminatory traditional attitudes and the prevailing negative influence of some manifestations of religious beliefs and cultural patterns in the State Party that hamper the advancement of women's rights, in particular sexual and reproductive health and rights.⁹³

In similar terms, the CEDAW Committee urged Ghana to "raise community awareness with regard to negative cultural beliefs" and to ensure that women have a choice as regards access to health care services, in particular in relation to reproductive health.⁹⁴ The CEDAW Committee recommended that Congo study the

⁸⁹ CEDAW Committee, Concluding Observations Kenya (CEDAW/C/KEN/CO/7 2 February 2011) para 39.

⁹⁰ CEDAW Committee, Concluding Observations Chad (CEDAW/C/TCD/CO/1-4 21 October 2011) para 35b.

⁹¹ CEDAW Committee, Concluding Observations Afghanistan (CEDAW/C/AFG/CO/1-2 23 July 2013) paras 36, 37.

⁹² CEDAW Committee, Concluding Observations Afghanistan (CEDAW/C/AFG/CO/1-2 23 July 2013) paras 36, 37.

⁹³ CEDAW Committee, Concluding Observations Paraguay (CEDAW/C/PRY/CO/6 21 October 2011) para 18; CEDAW Committee, Concluding Observations Costa Rica (CEDAW/C/CRI/CO/5-6 29 July 2011) para 18.

⁹⁴ CEDAW Committee, Concluding Observations Ghana (CEDAW/C/GHA/CO/5 25 August 2006) para 32.

behavioural patterns of communities, and of women in particular, that inhibit their utilisation of existing services.⁹⁵ In the case of Malawi, the CEDAW Committee encouraged the State Party to enhance work with community leaders and health workers so as to decrease and eventually eliminate the negative impact of traditional practices on women's health. It was particularly alarmed by the direct linkage between harmful traditional practices and the spread of HIV/AIDS.⁹⁶

Sometimes the CEDAW Committee more explicitly refers to cultural patterns or practices, for instance concerning health-related operations for which women need male permission. An example is Bahrain, concerning which the CEDAW Committee expressed its distress that women need authorisation from their husbands before a caesarean-section delivery is performed. It urged the State Party to take measures to allow women to undergo this procedure on the basis merely of their own consent.⁹⁷ Interestingly, Bahrain was several years later praised for its decision to reverse this practice.⁹⁸ The CEDAW Committee further called on St Lucia to ensure that women do not require, in law or in practice, their husband's written consent for the performance of tubal ligation.⁹⁹

In accordance with their General Recommendations on FGM, the CEDAW Committee and the CRC Committee have been firm in their rejection of this practice. The CEDAW Committee has consistently stated that it considers FGM "a grave violation of girls' and women's human rights and of the State party's obligations under the Convention".¹⁰⁰

⁹⁵ CEDAW Committee, Concluding Observations Congo (CEDAW/C/COD/CO/5 25 August 2006) para 36.

⁹⁶ CEDAW Committee, Concluding Observations Malawi (CEDAW/C/MWI/CO/5 3 February 2006) paras 31, 32.

⁹⁷ CEDAW Committee, Concluding Observations Bahrain (CEDAW/C/BHR/CO/2 7 November 2008) paras 36, 37.

⁹⁸ CEDAW Committee, Concluding Observations Bahrain (CEDAW/C/BHR/CO/3 10 March 2014) para 41.

⁹⁹ CEDAW Committee, Concluding Observations St Lucia (CEDAW/C/LCA/CO/6 2 June 2006) para 32.

¹⁰⁰ CEDAW Committee, Concluding Observations Guinea (CEDAW/C/GIN/CO/6 10 August 2007) para 24; CEDAW Committee, Concluding Observations Mauritania (CEDAW/C/MRT/CO/1 11 June 2007) para 27; CEDAW Committee, Concluding Observations Sierra Leone (CEDAW/C/SLE/CO/5 11 June 2007) paras 22, 23; CEDAW Committee, Concluding Observations Ethiopia

The CEDAW Committee has strongly urged States Parties to eliminate this practice and its underlying cultural justifications, including taking measures in the field of education and awareness-raising and punishing offenders. In other words, States Parties are obliged to ensure the abandonment of FGM not only in law, but also in practice. For instance, in the case of Oman the Committee welcomed the prohibition of the performance by medical doctors of FGM in hospitals, but it noted that it seemed that the practice prevailed and perhaps took place clandestinely in other settings, or was perhaps performed by non-medical personnel. The Committee therefore urged Oman to

... develop a plan of action and undertake efforts to eliminate this harmful practice through awareness-raising among opinion leaders in the communities as well as religious leaders, health and education professionals and the general population ... and to speedily enact legislation prohibiting FGM and ensure that perpetrators are prosecuted and adequately punished.¹⁰¹

Similar recommendations were made to Mali, where the Committee was also concerned

... at the high incidence of this harmful traditional practice and the State party's reluctance to expedite the adoption of legislation aimed at eradicating this violation of a woman's human rights.¹⁰²

Kenya, Guinea Bissau and the Central African Republic were also urged to increase their awareness-raising and education efforts targeting families, practitioners and medical personnel, in order to eliminate female genital mutilation as well as its underlying cultural justifications.¹⁰³ Other cultural practices identified by the CEDAW

(CEDAW/C/ETH/CO/6-7 29 July 2011) para 19; CEDAW Committee, Concluding Observations Djibouti (CEDAW/C/DJI/CO/1-3 29 July 2011) para 19.

¹⁰¹ CEDAW Committee, Concluding Observations Oman (CEDAW/C/OMN/CO/1 21 October 2011) paras 25, 26.

¹⁰² CEDAW Committee, Concluding Observations Mali (CEDAW/C/MLI/CO/5 3 February 2006) paras 25, 26.

¹⁰³ CEDAW Committee, Concluding Observations Kenya (CEDAW/C/KEN/CO/7 2 February 2011) para 20; CEDAW Committee, Concluding Observations Guinea Bissau (CEDAW/C/GNB/CO/6 7 August 2009) para 26; Central African Republic (CEDAW/C/CAF/CO/1-5 24 July 2014) para 25, 26.

Committee as harmful to health are selective abortions¹⁰⁴ and early and forced marriages.¹⁰⁵

The CRC Committee has also often dealt with cultural practices harmful to the health of children. Such practices are infanticide and selective abortions¹⁰⁶, early and forced marriages¹⁰⁷, ritual killings¹⁰⁸ and FGM.¹⁰⁹ States Parties are consistently urged to eradicate these practices in law and in fact, including addressing their underlying cultural traditions and beliefs. Other more specific traditional practices are also discussed. For instance in relation to Myanmar, the CRC Committee urged the State Party to increase its awareness-raising activities among several tribes on the potential risks of their traditional practice of neck elongation for their physical well-being. The CRC Committee indicated that this practice can result in sudden death or serious damage to the spinal cord if the neck-elongation ring is removed.¹¹⁰

The above shows that while the promotion of the cultural dimension of the right to health is recognised and addressed, most attention is paid to situations where

¹⁰⁴ CEDAW Committee, Concluding Observations China (CEDAW/C/CHN/CO/7-8 7 November 2014) paras 38, 39.

¹⁰⁵ CEDAW Committee, Concluding Observations Georgia (CEDAW/C/GEO/CO/4-5 24 July 2014) para 18,19; Ghana (CEDAW/C/GHA/CO/6-7 7 November 2014) paras 23, 41.

¹⁰⁶ CRC Committee, Concluding Observations Benin (CRC/C/BEN/CO/2 20 October 2006) paras 30, 31; CRC, Concluding Observations China (including Hong Kong and Macau Special Administrative Regions) (CRC/C/CHN/CO/2 24 November 2005) paras 28, 29; Concluding Observations Russian Federation (CRC/C/RUS/CO/3 23 November 2005) paras 28, 29; Concluding Observations Tunisia (CRC/C/TUN/CO/3 16 June 2010) para 25-2; Concluding Observations India (CRC/C/15/Add.228 26 February 2004) para 34b; Concluding Observations Maldives (CRC/C/MDV/CO/3 13 July 2007) paras 42, 43; Concluding Observations Senegal (CRC/C/SEN/CO/2 20 October 2006) paras 50, 51; Concluding Observations Niger (CRC/C/NER/CO/2 18 June 2009) para 59; India (CRC/C/IND/CO/3-4 7 July 2014) paras 32, 33.

¹⁰⁷ CRC Committee, Concluding Observations, Senegal (CRC/C/SEN/CO/2 20 October 2006) paras 50, 51; Niger (CRC/C/NER/CO/2 18 June 2009) paras 59-61; Mali (CRC/C/MLI/CO/2 3 May 2007) paras 52, 53; Timor-Leste (CRC/C/TLS/CO/1 14 February 2008) paras 62, 63; Uganda (CRC/C/UGA/CO/2 23 November 2005) paras 55, 56; Sudan (CRC/C/SDN/CO/3-4 22 October 2010) paras 56, 57; Sierra Leone (CRC/C/SLE/CO/2 20 June 2008) paras 57, 58; Morocco (CRC/C/MAR/CO/3-4 14 October 2014) para 42, 43; Indonesia (CRC/C/IDN/CO/3-4 10 July 2014) para 36; Jordan (CRC/C/JOR/CO/4-5 8 July 2014) paras 33, 34; Russian Federation (CRC/C/RUS/CO/4-5 25 February 2014) paras 37, 38.

¹⁰⁸ CRC Committee, Concluding Observations Uganda (CRC/C/OPSC/UGA/CO/1 16 October 2008) paras 17, 19; United Republic of Tanzania (CRC/C/OPSC/TZA/CO/1 10 October 2008) paras 20, 21; Nigeria (CRC/C/15/Add.257 13 April 2005) para 56.

¹⁰⁹ CRC Committee, Concluding Observations Indonesia (CRC/C/IDN/CO/3-4 May-June 2014) para 33, 34; Congo (CRC/C/COG/CO/2-4 25 February 2014) paras 62, 63; Yemen (CRC/C/YEM/CO/4 25 February 2014) para 49.

¹¹⁰ CRC Committee, Concluding Observations Myanmar (CRC/C/15/Add.237 30 June 2004) paras 58, 59.

culture has a negative impact on the enjoyment of the right to health. UN treaty monitoring bodies have extensively dealt with cultural practices harmful to people's health, and with cultural attitudes and stereotypes obstructing the right to health. They have identified several practices that they consider to be so harmful that they should be eradicated, recommending a multifaceted approach involving not only adopting legislation but also measures in the field of education, awareness-raising and sensitisation.

Some criticism has been expressed about the way that UN treaty monitoring bodies have defined harmful practices and have selected practices within this category. It is argued that the list of harmful practices includes almost exclusively practices that originate from non-Western cultural traditions. Some have therefore accused the UN treaty bodies of being biased in their assessment of traditional practices, having a too Western-centric vision of these practices.¹¹¹ It is therefore interesting to see how a non-Western regional human rights system, namely the African system, has dealt with these issues. To what extent do African human rights treaties and African monitoring bodies interpreting these treaties take a different approach?

4 The right to health in African human rights treaties

In the African Charter on Human and Peoples' Rights the right to health is included in Article 16, which reads as follows:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Special attention is paid to the health of women in the African human rights system. The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2003) includes a provision on health and sexual and reproductive rights (Article 14). These rights include the right to control their fertility, to decide whether and when to have children, to choose any method of contraception and receiving information, and educational rights. In the Protocol there is no explicit

¹¹¹ Tobin *Right to Health* 310-311.

reference to the cultural dimension of these health-related rights. Culture is mentioned, however, in relation to violence against women, which clearly has a link with health. In Article 4(1)d of the Protocol, States Parties are called upon to actively promote the eradication of traditional and cultural beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women.

5 Monitoring by the African Commission on Human and Peoples' Rights

The *African Charter on Human and Peoples' Rights* established the African Commission on Human and Peoples' Rights, an independent body monitoring State Parties' implementation of and compliance with the Charter. The Commission has several procedures at its disposal to fulfil its monitoring function, including a State reporting procedure. Article 62 of the Charter requires States Parties to submit periodic reports to the Commission. Article 26 of the Women's Protocol also requires States Parties to this Protocol to include in their periodic reports to the Commission information on legislative and other measures they have taken to implement the provisions of this Protocol. The Commission then engages in a dialogue with the States Parties to identify achievements and challenges as regards the implementation of the Charter. Since 2001 the Commission has adopted Concluding Observations in which it addresses both positive and negative aspects of the States Parties' implementation of the treaty and specifies the steps to be taken by the State Party to remedy the shortcomings identified. The Concluding Observations are not legally binding.

The African Commission has further installed several so-called special mechanisms to investigate human rights violations, research human rights issues and undertake promotional activities through country visits. The Working Group on Indigenous Populations/Communities in Africa is such a mechanism. The reports of these working group or rapporteurs may form the basis of resolutions of the Commission.

The African Commission may also receive complaints from individuals and NGOs against States Parties on alleged violations of human rights, in accordance with

articles 48, 49 and 55 of the African Charter, after local remedies have been exhausted. The outcome of the procedure is not legally binding.¹¹² Several individual cases concerned *inter alia* the right to health, but the cultural dimensions of health did not play a decisive role in the outcome of the cases. For instance, in the Ogoni case the Commission concluded that the Nigerian government had violated the right to health of the indigenous Ogoni people by not preventing or punishing the contamination of air, water and soil of the Ogoni land.¹¹³ A similar approach was taken in the case against Sudan on the situation in Darfur, where the destruction of foodstuffs, crops and livestock, the poisoning of wells, and the denial of access to water sources resulted in a violation of the right to health.¹¹⁴ Cultural aspects were, however, not specifically addressed.

Below, several statements and resolutions by the African Commission relevant to culture and health are discussed. Afterwards the Concluding Observations on several States taking part in the reporting procedure from 2008-2014 are dealt with. It should be noted that State reports are not submitted on a regular basis and therefore the Concluding Observations represent examples but do not draw the full picture of the implementation of the right to health in African States.

5.1 Statements and Recommendations

The statements and recommendations of the African Commission have broadly followed the approach taken by the UN treaty monitoring bodies discussed above. For instance, in its Resolution on Access to Health and Needed Medicines in Africa, the African Commission followed the approach of the ESC Committee as regards the right to health and repeated that the acceptability of health services includes the acceptability of supplies of medicines, "being respectful of cultural norms and

¹¹² The African human rights system also has an African Court of Justice and Human Rights, established by the *Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights*, adopted in June 1998. The Protocol came into force on 25 January 2004 after it was ratified by more than 15 countries. The Court started its work in 2006 and it has since 2008 dealt with several cases. Since none of these cases concern health, they are not dealt with here.

¹¹³ *Social and Economic Rights Action Center and the Center for Economic and Social Rights v Nigeria* ACHPR Comm No 155/96 (2001) para 52.

¹¹⁴ *Centre on Housing Rights and Evictions v The Sudan* ACHPR Communication Nos 279/03 and 296/05 (2009) para 212.

medical ethics".¹¹⁵ It further called upon states to promote (equal) access to medicines. This should include refraining from measures that negatively affect access, such as "prohibiting or impeding the use of traditional medicines and healing practices that are scientifically sound and medically appropriate".¹¹⁶

In a Resolution on the Health and Reproductive Rights of Women in Africa the African Commission expressed its concern about the continuing practice of FGM despite national legislation outlawing it, calling FGM a harmful practice affecting the reproductive health of women. In this resolution the Commission urged States to ensure the eradication of this practice and to continue awareness-raising among all sectors of society.¹¹⁷

5.2 State reports and Concluding Observations

The reports by the African Commission and its working groups show that it has not (yet) extensively dealt with the cultural dimensions of the right to health. When discussed, the issues appear to be similar to those described above, focusing on access to health services and medicine on a non-discriminatory basis; special attention for the particular health goods and services of indigenous peoples, and the eradication of harmful traditional practices, notably FGM.

5.2.1 Special measures to ensure equal access to health goods and services

General access to health goods and services is dealt with in many reports and recommendations by the African Commission and also by the working group on indigenous populations. (Equal) access to health care and services is clearly a major problem in African countries. As regards the promotion of access for cultural communities, the recommendations broadly mention minorities, indigenous peoples,

¹¹⁵ ACHPR *Resolution on Access to Health and Needed Medicines in Africa* (ACHPR/Res.141 (XXXXIII) 8 November 2008).

¹¹⁶ ACHPR *Resolution on Access to Health and Needed Medicines in Africa* (ACHPR/Res.141 (XXXXIII) 8 November 2008).

¹¹⁷ African Commission on Human and Peoples' Rights, meeting at its 41st Ordinary Session in Accra, Ghana, from 16 to 30 May 2007.

and people living in rural areas as vulnerable groups, but no specific culturally sensitive or appropriate measures are suggested.¹¹⁸

5.2.2 Respect for and protection of culture-specific health goods and services

Although the concepts of "cultural sensitivity" or "cultural appropriateness" are not used, the issue of the recognition and protection of culture-specific health goods and services has been addressed. For instance, the African Commission expressed positive remarks about Ghana, commending its efforts to encourage the protection of herbal and traditional medicine and the training of students on the development and administration of herbal medicines.¹¹⁹ Sometimes the State Party mentioned the recognition of traditional medicine in its report, but this point was not addressed by the Committee. Zimbabwe for instance mentioned its laws permitting traditional healers to practice traditional medicine without interference. These laws regulate the conduct of traditional healers, for example by precluding them from selling their medicines from unhygienic premises, and thereby they safeguard the interests of patients. Zimbabwe also stated that it carried out programmes to educate traditional healers on the need to use sterilised items, such as razor blades, when treating their patients.¹²⁰ Tanzania also included in one of its reports that the National Health Policy recognizes the role of traditional medicines and alternative healing systems.¹²¹ However, the Commission did not address these issues in its Concluding Observations.¹²²

The working group on indigenous populations has in several reports paid attention to the particular vulnerability of indigenous peoples to a lack of access to health services. It has maintained that indigenous peoples in Congo, for instance, suffered from growing inaccessibility to forests caused by government concessions for logging

¹¹⁸ ACHPR *Nigeria: 3rd Periodic Report* (2005-2008); ACHPR *Congo: Mission Working Group Indigenous Populations / Communities* (2010); ACHPR *Rwanda: Mission of Working Group Indigenous Populations / Communities* (2008); ACHPR *Kenya: Mission Working Group Indigenous Populations / Communities* (2010).

¹¹⁹ ACHPR *Ghana: Promotion Mission* (2008).

¹²⁰ ACHPR *Zimbabwe: 7th to 10th Periodic Report* (1996-2006). The Concluding Observations for Zimbabwe were not available.

¹²¹ ACHPR *Tanzania: Promotion Mission* (2008).

¹²² ACHPR *Concluding Observations and Recommendations on the Consolidated 2nd to 10th Periodic Report of the United Republic of Tanzania* (2007).

or transformation into forest reserves, which diminished access to their traditional medicine as well as the erosion of their knowledge and skills in the area of traditional medicine. Moreover, the lack of support by the government to train traditional birth attendants was of major concern to the working group.¹²³ Similar remarks were made with regard to Rwanda, where the working group noted that indigenous knowledge was being lost because indigenous peoples were prohibited from going to the forests to collect the needed leaves and barks.¹²⁴ In relation to Burundi, the working group noted with concern that Burundi had no specific health programme for indigenous peoples.¹²⁵

5.2.3 Combat harmful traditional and cultural practices

The African Commission has regularly paid attention to traditional and/or cultural practices that it considers harmful to people's health, in particular FGM. For instance, in relation to Tanzania the Commission expressed its grave concern about the continuing violations of the rights of women and children in Zanzibar, mentioning specifically the widespread practice of FGM, forced marriages, and the non-recognition of marital rape.¹²⁶ FGM was also mentioned as a traditional practice harmful to the health of women in Nigeria, Burkina Fasso, Niger and Ethiopia.¹²⁷

From these examples it appears that, as with the UN treaty bodies, the African Commission considers similar practices as harmful and is just as firm in ordering States to eradicate them. In other words, there seems to be consensus on at least some practices as being harmful. At the same time, both the UN treaty bodies and the African Commission realise that laws alone will not eradicate these practices and that a holistic approach is needed, including awareness-raising and education. Here

¹²³ ACHPR *Congo: Mission Working Group Indigenous Populations / Communities* (2010).

¹²⁴ ACHPR *Rwanda: Mission of Working Group Indigenous Populations / Communities* (2008).

¹²⁵ ACHPR *Burundi: Research and Information Visit Regarding Indigenous Populations / Communities* (2005).

¹²⁶ ACHPR *Tanzania: Promotion Mission* (2008).

¹²⁷ ACHPR *Nigeria: 3rd Periodic Report* (2005-2008); ACHPR *Concluding Observations and Recommendations on the Third Periodic Report of the Federal Republic of Nigeria* (2004); ACHPR *Concluding Observations and Recommendations on the Seventh and Eighth Periodic Report of the Republic of Burkina Faso* (2004) para 25; ACHPR *Concluding Observations and Recommendations on the Initial Report of the Republic of Niger* (2004) para 22; ACHPR *Concluding Observations and Recommendations on the Initial, 1st, 2nd, 3rd and 4th Periodic Report of the Federal Democratic Republic of Ethiopia* (2010).

also the involvement of the community concerned is crucial. The assessment of what constitutes harm, for instance, is fluid and subjective and often based on community considerations. Thus, not participating in a practice may prevent physical harm but may cause extensive psychological harm in the sense of the resultant feeling of exclusion and isolation.¹²⁸

6 The right to health and its cultural dimensions: concluding remarks

The right to health is included in many international and African human rights instruments. This right includes freedoms as well as entitlements and both of these have important cultural connotations. The various cultural dimensions of the right to health are recognised and elaborated in recommendations by treaty monitoring bodies at UN and African level. These bodies have endorsed the idea that health facilities, goods and services must be respectful of the culture of individuals, peoples and communities. At the same time, the right to health should be protected against the negative impact that cultural values, patterns or practices may have, for instance on access to health goods and services and on people's health.

The analysis shows that UN and African treaty monitoring bodies have recognised and addressed these different dimensions. They have, for instance, adopted the notion that health policies, goods and services should be "culturally appropriate" or "culturally sensitive". From the practice of these bodies several obligations of States can be induced that fall within these notions. These obligations include the adoption and implementation of special measures for cultural communities to ensure equal access to health goods and services and the recognition and protection of specific health goods and services of cultural communities. At the same time, the notion of "cultural appropriateness" should not be interpreted as providing the possibility to unjustifiably limit the enjoyment of the right to health. Therefore, States are also obliged to take measures to modify social and cultural patterns and eliminate prejudices and stereotypes that prevent certain individuals or groups of individuals, such as women, from enjoying their health rights. Moreover, States are obliged to eradicate cultural practices such as FGM, polygamy, and early and forced marriages,

¹²⁸ Tobin *Right to Health* 307, 314; Hendriks 2008 *EJHL* 293-294.

because they are harmful to the health of people.

The recommendations of the monitoring bodies are not legally binding, but they provide States Parties with guidelines on how to implement international and regional provisions in their national legal order. Their recommendations are therefore often formulated in rather broad terms and seldom provide detailed guidelines or instructions. The treaty monitoring bodies, in accordance with their complementary role as international supervisory bodies, leave room to States Parties to locally implement human rights provisions in the light of the particular local cultural circumstances.

The analysis of the situations in African States, through the UN reports and the reports of the African bodies, shows that some of the cultural dimensions of the right to health are still very challenging. In many African States, ensuring general access to health goods and services already remains a major challenge, let alone the adoption and implementation of special measures for particular cultural communities. Another challenge is the continuous conduct of harmful cultural practices in several African States. FGM, for instance, is a practice conducted mostly in African countries¹²⁹ and therefore this has been frequently addressed by UN and African treaty monitoring bodies. There appears to be a clear consensus at global and African level on several practices that are considered harmful. At the same time, it is realised that identifying a certain practice as harmful by an international body, even if agreed to by the State Party, is not sufficient to eradicate it.

Moreover, it is not always necessary to eradicate the practice or ritual in its entirety. The right to health requires merely that those aspects of these practices that are harmful to the health of people are abandoned. Perhaps alternative practices can be developed that do not harm the health of the persons involved, but that are still culturally acceptable.¹³⁰ It is therefore important to involve the cultural communities

¹²⁹ The World Health Organisation states that FGM is most common in the western, eastern, and north-eastern regions of Africa, although it is also practised in some countries in Asia and the Middle East. The WHO estimates that about 140 million girls and women worldwide are living with the consequences of FGM, of which about 101 million are estimated to have undergone FGM. See WHO 2014 <http://goo.gl/SK2M1z/>.

¹³⁰ Tobin *Right to Health* 305, 320.

concerned in the drafting, implementation and evaluation of health laws and policies.¹³¹ This could be more strongly emphasised by the monitoring bodies. Cultural communities are crucial in promoting social and behavioural changes that may be needed to eradicate harmful practices. Changes in cultural practices are most successful if they arise within the cultural community itself and are not imposed from outside, by law or by the State. This does of course not relieve States from the responsibility to find ways to promote such changes. As shown above, several treaties oblige States Parties to eradicate cultural practices that are harmful to people's health and monitoring bodies consistently emphasise these obligations.

The involvement of the cultural community, however, is also crucial in respecting and promoting the more positive cultural dimensions of the right to health. Cultural communities can play an important role in making health policies, goods and services culturally sensitive or culturally appropriate. Monitoring bodies could accordingly pay more attention to the involvement of cultural communities in the design of special measures that may be needed to ensure equal access to health goods and services and in the determination of those traditional health goods and services that deserve recognition and protection. By consulting cultural communities and the individuals concerned, States can implement the right to the highest attainable standard of health in a culturally sensitive, appropriate and responsible way.

¹³¹ Tobin *Right to Health* 265, 301; Hendriks 2008 *EJHL* 292.

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LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights / African Commission on Human and Peoples' Rights
Asian JIL	Asian Journal of International Law
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDAW Committee	Committee on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRC Committee	Committee on the Rights of the Child
EJHL	European Journal of Health Law
ESC Committee	Committee on Economic, Social and Cultural Rights
FGM	Female genital mutilation
Hum Rts Q	Human Rights Quarterly
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
Int Soc Sci J	International Social Science Journal
OHCHR	Office of the High Commissioner for Human Rights
UN	United Nations
WHO	World Health Organisation

EXPLORING THE CULTURAL DIMENSIONS OF THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

YM Donders*

SUMMARY

The right to enjoying the highest attainable standard of health is incorporated in many international and regional human rights instruments. This right contains both freedoms and entitlements, including the freedom to control one's own health and body and the right to an accessible system of health care, goods and services.

Both aspects of the right to health – freedoms and entitlements – have important cultural dimensions. The UN Committee on Economic, Social and Cultural Rights has for instance stated that the right to health implies that health facilities, goods and services must be culturally appropriate, in other words respectful of the culture of individuals and communities. At the same time, it should be noted that culture and health may have a problematic relationship. Cultural patterns, attitudes or stereotypes may severely limit the health freedoms of people or may prevent certain people from accessing health care. Furthermore, there are some cultural or traditional practices that are condoned but that are very harmful to people's health.

It seems that international human rights law demands respect for the cultural dimensions of the right to health, while at the same time requiring protection of the right to health against negative aspects of cultures. How does this work out in practice? What does the concept of "culturally appropriate" health goods and services mean at the national level? Who decides on what is or is not culturally appropriate? How have international supervisory bodies elaborated on the freedoms and entitlements of the right to health and the obligations for States Parties to the treaties in relation to the cultural dimensions of the right to health?

This article analyses several treaty provisions and the interpretation of these provisions by the treaty monitoring bodies. Apart from several UN treaties, several regional

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treaties in Africa are dealt with, notably the African Charter on Human and Peoples' Rights. The article concludes that various cultural dimensions of the right to health are recognised and elaborated upon in recommendations by treaty monitoring bodies both at UN and African level. These bodies have endorsed the idea that health facilities, goods and services must be respectful of the culture of individuals, peoples and communities. At the same time, the right to health should be protected against the negative impact that cultural values, patterns or practices may have, such as on access to health goods and services and on the health of people as such. The latter issue has received most attention at the UN as well as at African level, and there appears to be a clear consensus on several practices that are considered harmful.

It is also realised, however, that the identification of a certain practice as harmful by an international body, even if agreed to by the State Party, is not sufficient to eradicate it. Cultural communities are crucial in promoting social and behavioural changes that may be needed to eradicate harmful practices. It is therefore important to involve the cultural communities concerned in the drafting, implementation and evaluation of health laws and policies. This could be more emphasised by the monitoring bodies. The involvement of the cultural community is also crucial to respecting and promoting the more positive cultural dimensions of the right to health. By consulting the cultural communities and individuals concerned, States can implement the right to the enjoyment of the highest attainable standard of health in a culturally sensitive, appropriate and responsible way.

KEYWORDS: Culture, cultural diversity, health, human rights, right to health, traditional practices.