The Role of Surgery in Global Health:
Addressing the crisis - Anesthesia, Surgical need and Global Health dialogue
Friday, November 5, 2010, Harvard Club – 374 Commonwealth Avenue, Boston

3:00 pm  The Right to Essential and Emergency Surgery
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I. INTRODUCTION
First of all I wish to express my heartfelt appreciation to the sponsors for organizing this timely event and especially to HHI, where I am proud to be a faculty affiliate. However, I must say how intimidating it is to be one of the very few non-surgeons at this conference and —along with my colleague in the Department of Global Health and Population—one of the two non-medically-trained speakers on a program dealing with surgery, the epitome of medical interventions! Since you have not invited me here to say anything useful about surgery, it must be that you want me to bring a perspective that might advance public policy of interest to the surgeon and to global health.

My task is to explore whether and to what extent “the right to essential and emergency surgery is integral to the right to health” and explain how we can get from the current situation, in which there is no such right in international human rights, to a presumably preferable situation in which the right is recognized and implemented. The assumed practical value is that the burden of surgery in global health will be reduced if the means and methods of international human rights are applied to the putative human right to essential and emergency surgery, which I will call “REES.”

My task is further complicated by the fact that one of the co-organizers, Kelly McQueen, has co-authored a splendid study on “Essential Surgery: Integral to the Right to Health,” which renders useless my comments today. Since I am an admirer of their pioneering work, let me at least honor it by making a few critical observations, which is very hard to do. I am, nevertheless, grateful to them for letting a rather minor error creep in so that I can have something critical to say. I’m sure they know better than to say that the UDHR was “ratified in 1949” whereas it was not ratified but adopted (there is a significant difference in international law) and not in 1949 but 1948. To continue in this nit-picking vein, when McQueen et al write that the key international treaty for our purpose, the International Covenant on Economic, Social and Cultural Rights, “requires States to provide the ‘highest attainable standard of physical and mental health’ for its citizens”, they overlook the fact that the rights reaffirmed in the Covenant belong to “everyone” (not just citizens) although article 2(3) does allow “Developing countries, with due regard to human rights and their national economy, [to] determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.” Unless they invoke that provision, the right to health is a “right of everyone” and not just citizens. They rely—as they should—on the interpretations of the Committee on Economic, Social and Cultural Rights in the form of a general comment but erroneously attributed wording to the Covenant that is only in the General Comment. So when McQueen et al write that the Covenant “states that ‘[t]he right to treatment includes the creation of a system of urgent medical care in cases of accidents’”, they erroneously attribute expert opinion to

2 Ibid., p. 137.
3 Ibid., p. 139, citing correctly para. 16 of General Comment 14 in the note.
the text of the Covenant whereas it is a quote from the General Comment. The final minor
disagreement I have with them is that they affirm “Therefore, surgical care for emergency obstetric
care, treatment of disease, and urgent care are all part of the recognized core obligations of states,
and failure to comply with these obligations cannot be justified under any circumstance”.\(^4\) This is
wishful thinking or at best an extension of the enumeration of core obligations by the Committee
but not what the Covenant or the Committee actually say about core obligations.\(^5\) I know they fully
understand the difference between the Covenant and the General Comment but it is important to be
aware that “emergency obstetric care, treatment of disease, and urgent care” are not part of the
recognized “core obligations” under the current interpretation by the Committee. Maybe that is
what we want the Committee to say at some stage. It is a significant point because a core obligation
is not subject to available resources and in fact the authors seem to contradict their position that
REES is not subject to resource constraints, when they say “Within the context of resource
constraints, states must make decisions about how to use existing resources for the greatest benefit,
and surgical care is viewed as competing with other types of treatment and prevention for limited
resources.”\(^6\) They go on to make the case for cost-effectiveness but still within this unavoidable
context of competing for resources, which does not apply to core obligations. This ambiguity gets
to the heart of whether and how REES is or should be formally recognized as integral to the RTH.
These few observations may of more interest to the lawyer than the surgeon. It may be more useful
to focus on the argument that may be invoked to enhance recognition of REES as a human right.

II. BUILDING THE CASE FOR A COMPONENT RIGHT

There are three arguments for maintaining that a given health policy rises to the level of a
component of the right to health. The first is that no new right should be proposed unless and until

\(^4\) Ibid., p. 139.
\(^5\) The authors indicate correctly that paragraph 47 of GC 14 says that States parties must comply with the
core obligation listed in para. 43. But that para. lists these core obligations: (a) To ensure the right of access
to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or
marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and
safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and
sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to
time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of
all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan
of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population;
the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and
transparent process; they shall include methods, such as right to health indicators and benchmarks, by which
progress can be closely monitored; the process by which the strategy and plan of action are devised, as well
as their content, shall give particular attention to all vulnerable or marginalized groups. That list does not
include “urgent medical care in cases of accidents,” nor is it found in the “obligations of comparable
priority” listed in para. 44, which include: (a) To ensure reproductive, maternal (pre-natal as well as post-
natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in
the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To
provide education and access to information concerning the main health problems in the community,
including methods of preventing and controlling them; (e) To provide appropriate training for health
personnel, including education on health and human rights.”

\(^6\) Ibid. p. 139.
there is overwhelming evidence regarding the magnitude of the problem to overcome the presumption against proliferation of new rights. Then there must to an undeniable logic to that integration. And third, the putative right must have a serious prospect of being legally enforceable.

**Burden of disease as a condition for recognizing rights derivative from the right to health**

The case has been made throughout this conference that the burden of surgical disease and the costs of essential and emergency surgery combine to make the case that, rather than a luxury to the distant future when currently poor countries have an effective health system, REES is already a component of the right to health and therefore all states have a duty to ensure that it is available to patients. The assumption is that, if REES is properly a human right then it justifies priority in the allocation of resources.

These considerations bring to mind the reasoning used in three other examples of expanding the recognized human rights, with which I have been involved, namely, tobacco control and access to medicines.

**Essential medicines:** Similarly, the argument for a human right to essential medicines begins with the global burden of disease, noting that nearly two billion people do not have access to essential medicines and an estimated four million people could be saved annually in Africa and Southeast Asia if diagnosis and treatment with appropriate medicines were available. The point has been made that the cost of one dose of a medicine can be low but if it is required to control a disease, over the long run it can be very experience and involve the risk that resources will dry up and those dependant on the drug will be abandoned, whereas, most EES is one-off and can be effective at a fraction of the cost in a high tech hospital in a rich country. Thus if the right to essential medicines is a component of the right to health then *a fortiori* REES is as well.

**Water and sanitation:** The right to water and sanitation is derived from the rights to life, to health and to food. The political will to do so is not only the result of the compelling urgency and threats to water but also by the fact that governments and civil society have made it a priority, as illustrated by UNDP’s Human Development Report 2006 called *Beyond scarcity: Power, poverty and the global water crisis*, which builds on the fact that the water crisis leaves 1.2 billion people without access to safe water and 2.6 billion without access to sanitation and forthrightly states “The starting point and the unifying principle for public action in water and sanitation is the recognition that water is a basic human right.”

**Tobacco control:** On tobacco control, for example, we noted “it is now recognized as the only legal product that, when used as intended, kills 50 percent of its consumers. Over 5 million die from tobacco-related deaths every year. It is the leading preventable cause of death in the world.”

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9 Carolyn Dresler and Stephen Marks, “The Emerging Human Right to Tobacco Control,” *Human Rights*
burden of disease from tobacco use was thus the starting point for the claim that tobacco control is itself a right integral to the right to health.

The case is not hard for surgery. McQueen et al cite recent estimates, citing WHO, that 11% of the Global Burden of Disease can be treated with surgery—which they consider a low estimate. Dean Jameson has explained to this conference the controversy surrounding this estimate. Whatever the accurate estimate, the burden of surgical disease is great enough to overcome the presumption against proliferation of new rights.

Compelling logic for the right
After determining if the magnitude of the problem justified the concern of the international community to even place it on the agenda of candidate human rights, a second condition for advancing a new human right is whether there is a firm logical fit within the existing human rights framework. In other words, is this a new concept, disrupting the carefully constructed framework of internationally protected human rights, or is it more or less the logical consequence or clarification of what exists? The case for REES is easy to make from this perspective since essential treatment and care are part of the existing right to the highest attainable standard of physical and mental health and REES does no more that clarify what that means when it comes to invasive procedures. REES may be seen as inseparable from the rights to life and health as a matter of legal analysis. It is undeniable that failure the recognize REES results in denial of both of these rights. This is basically coterminous with the public health argument that, without access to essential and emergency surgery, it is inconceivable to put in place a functioning health system and reduce morbidity and unnecessary mortality.

Legal feasibility of the right
Third, is the putative right to essential and emergency surgery clearly feasible in economic, political and legal terms? Thus, the real problem is whether we actually expect RESS to be protected by national legislation and enforce by the courts.

The way human rights norms become part of the accepted corpus of internationally recognized human rights is a complex process involving most—and sometimes all—of these stages: the Generation of interest in an issue by delegates in a deliberative body → decision to make a study or to hold a “day of general discussion” or its equivalent → completion of a study concluding that a normative instrument is called for → convening of a body to draft a legal instrument → adoption of an instrument of a non-binding character (resolution, declaration, plan of action) → experience with the application of the standard → decision to transform the non-binding standard into a binging instrument (treaty) → drafting by a group of government representatives of a treaty → adoption and opening for signature of the treaty → signature and ratification of the treaty → monitoring of the treaty through reports → reinforcing and clarifying obligations of the treaty through Concluding Observations and General Comments → decision to complement the treaty with a protocol giving the right to petition an expert body → drafting, adopting and opening for signature of the additional

The right to essential and emergency surgery can bypass most of these procedures since the right to health already exists in a major general human rights treaty, which has an optional protocol, and in numerous UN normative instruments\textsuperscript{10} and regional human rights treaties.\textsuperscript{11} Rather than begin the process anew for the recognition of a new REES, the process is more one of ensuring that the bodies responsible for interpreting and applying the right to health acknowledge that RESS is an integral part of that right.

**Consideration of the component right by human rights bodies**

Let us follow the trajectory of the right to essential medicines to see how this works in order to assess the prospects for REES. In 2001 the Commission on Human Rights adopted a resolution on access to medication in the context of pandemics such as HIV/AIDS, and the Office of the High Commissioner issued a report on the impact of the TRIPS Agreement on human rights, while the Sub-Commission on the Promotion and Protection of Human Rights adopted a resolution the same year on “Intellectual Property Rights and Human Rights.” These positions found support in the Doha Declaration on the TRIPS Agreement and Public Health.\textsuperscript{12} In an unusually direct statement emanating from the WTO, better known for highly technical and legally complex sentences, the declaration added, “In this connection, we reaffirm the right of WTO members to … grant compulsory licences and the freedom to determine the grounds upon which such licences are granted ... [and] the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.” We must observe here that, in spite of the significant victory for the principle of TRIPS flexibilities, in practice, they are extremely rare a decade after Doha. Let me also recall that on 26 November 2001 the Committee on ESCR held a ‘day of general discussion’ on Article 15(1)(c), following which it issued a ‘Statement on Human Rights and Intellectual Property’, in which it made explicit reference to the development of new medicines in the context of the Doha Declaration on the TRIPS Agreement and Public Health as an example of the need to strike a balance between the right to enjoy the benefits of scientific progress and its applications under Article 15(1)(b) and the right to benefit from the protection of the moral and

\textsuperscript{10} Article 25 (1) of the Universal Declaration of Human Rights (UDHR), article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), article 24 of the Convention on the Rights of the Child (CRC) and article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).


\textsuperscript{12} “The TRIPS agreement does not and should not prevent members from taking measures to protect public health ... in particular to promote access to medicines for all.”
material interests under Article 15(1) (c). In 2000 the Committee had clarified further the human right to essential medicines in its General Comment 14, had interpreted the obligation under Covenant Article 12(2)(d) of the Covenant (“The creation of conditions which would assure to all medical service and medical attention in the event of sickness”) to include “the provision of essential drugs.” In clarifying the obligations of states parties, the Committee included among the facilities, goods and services that must be available in sufficient quantity within the state “essential drugs, as defined by the WHO Action Programme on Essential Drugs”.

None of this has happened for REES because so far there have been no governments or NGOs, like Brazil and MSF in the case of medicines, to raise the issue of EES in these fora. Where the parallel exists is with respect to WHO, which has an equivalent program to the Action Programme on Essential Drugs. The Global Initiative for Emergency and Essential Surgical Care (GIEESC)\(^{13}\) and the WHO Integrated Management for Emergency & Essential Surgical Care e-learning toolkit (CD)\(^{14}\) provide the professional basis for the claim that EES is integral to the RTH but the crossover from the technical agency to the human rights bodies has not occurred. These WHO activities and the work of the Disease Control Priorities Project, the Global Burden of Disease Working Group, and scholars such as Dean Jameson and Charles Mock and many other present here provide a similar answer to the question the human rights specialists asks of essential medicines: what is included and what is excluded and is it affordable? If REES is to be accepted as integral to the RTH, that message has to reach the relevant human rights bodies.

The change will depend in part on drawing attention to what is evident to everyone here but not to the human rights community, namely, that surgery of the sort considered by the medical profession to be essential can be made available, accessible, appropriate and of quality as a matter of right including for populations living in poverty or humanitarian emergency.

III. CIVIL SOCIETY ACTIVISM AND LITIGATION ON BEHALF OF THE RIGHT TO ESSENTIAL AND EMERGENCY SURGERY

Even without a concerted campaign on behalf of REES, a trend of national court action and civil society activism is begin to emerge. Let’s examine a few national high court cases and studies by a human rights NGO traditionally associated with the defense of civil and political rights and one by an NGO more engaged with physicians.

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\(^{13}\) Established to improve collaboration among organisations and institutions involved in reducing death and disability from road traffic accidents, burns, falls, pregnancy related complications, domestic violence, disasters and other emergency surgical conditions.

\(^{14}\) Developed by the Clinical Procedures Unit in collaboration with the GIEESC programme. This tool targets policy-makers, managers, and health-care providers (surgeons, anaesthetists, non-specialist doctors, health officers, nurses, and technicians). This tool contains WHO recommendations for minimum standards in emergency, surgery, trauma, obstetrics and anaesthesia at first-referral level health-care facilities.
Litigation of the right to essential and emergency surgery in national courts

In the mid-1990s, the Indian Supreme Court issued a landmark judgment on the right to admission and treatment in emergencies in *Paschim Bangal Khet Mazdoor Samiti v. State of West Bengal*.15 The case involved a patient with serious head injuries who received first aid in a primary health center. After being referred from one government hospital to another without being admitted or provided emergency treatment, he went to a private hospital claiming a fundamental right to health. The Indian the Supreme Court held that the state was obliged to provide emergency treatment. The Court said “a patient should not be refused admission when his condition is grave,” and that “the Superintendent [of the hospital] should have given guidelines to respective medical officers for admitting serious cases under any circumstances.” It further stated “that the guiding principle should be to ensure that no emergency case is denied medical care. All possibilities should be explored to accommodate emergency patients in serious condition” and issued detailed guidelines.16

A particularly telling example of the judicial examination of ESCR, including allocation of resources, is provided by the Constitutional Court of South Africa, which decided in the Soobramoney case in 1997 that —the state has to manage its limited resources and, in this case of a man suffering kidney failure, would not require the state to provide renal dialysis under the right to health because to do so —the health budget would have to be dramatically increased to the prejudice of other needs which the state has to meet.17 Then, in *South Africa v Grootboom* in 2000, the Court interpreted the right to adequate housing as requiring the state to —provide relief for people who have no access to land, no roof over their heads, and who are living in intolerable conditions or crisis situations.18 For present purposes, it is worth highlighting the Court’s dictum: “The question is therefore not whether socio-economic rights are justiciable under our Constitution, but how to enforce them in a given case.”19 In 2002, the Court decided, in the landmark *Treatment Action Campaign* case, that the constitutional guarantee of the right to health required the government to provide to pregnant women a drug known to reduce mother-to-child transmission of HIV, noting that the government “has to find the resources ‖‖ to comply with a court order and [w]here a breach of any right has taken place, including a socio-economic right, a court is under a duty to ensure that effective relief is granted.”20

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16 “Primary health centers should be equipped with adequate facilities to ensure basic treatment to patients, stabilizing their condition before referral. Hospitals at the district and sub-division levels should be upgraded so that they can provide care in serious cases. Number of facilities available for specialist treatment should be increased to meet the growing need, and such facilities should be available at the district and subdivisional level hospitals. A centralized communication system should be put in place at the state level so that patients can be directed to a hospital which has the required care and free beds for admitting such patients. Patients should be transported from primary health centers to higher facilities for care in ambulances. Proper arrangements should be made to ensure that there are a sufficient number of ambulances equipped with facilities and medical personnel.”
17 Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC) paras. 28, 31 (S. Afr.).
18 60. South Africa v Grootboom 2001 (1) SA 46 (CC) para. 99 (S. Afr.).
19 Id. para. 20.
20 Minister of Health v Treatment Action Campaign 2002 (5) SA 721 (CC) para. 99 (S.
firmly as a right for all, illustrate that litigation of the right to health is regarded as a normal result of a state recognizing this right in its constitution and international treaties, even though it is necessary (and I would say reasonable) to set limits on how much the states is expected to expend on expensive surgery or other medical treatment.

**Civil Society Advocacy**

Although it is better known for activism on behalf of civil and political rights, Human Rights Watch issued an 82-page report on July 15, 2010, describing “the devastating condition facing women with fistula in Kenya” and the failures of the health system to provide access to emergency obstetric care, including referral and transport systems affordable maternity care and fistula repair. It also documents stigma and violence many fistula sufferers face. Among its detailed recommendations are to “Urgently improve financial accessibility of fistula surgery by subsidizing routine repairs in provincial and district hospitals, including follow-up visits, and providing free fistula surgeries for indigent patients” and to “Urgently strengthen emergency obstetric care” and with respect to Facilities and Training of Fistula Surgeons, Human Rights Watch made an additional three recommendations. Similarly, in a HRW report on India, entitled, *No Tally of the Anguish: Accountability in Maternal Health Care in India*, HRW found that “the vast majority of women in rural India have poor access to emergency obstetric care that could save their lives, including blood transfusions and cesarean sections.” The report acknowledges that “Since mid-2005, basic and comprehensive emergency obstetric care are covered by the NRHM (National Rural Health Mission) service guarantees” … but “there has been little or no improvement in women's access to

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22 1. Scaling up the number of health facilities that offer emergency obstetric care and intensifying efforts to meet the recommended ratios for staffing in health facilities. 2. Developing and implementing guidelines on the management of obstructed labor and oversight of this health service in line with the WHO’s handbook on monitoring emergency obstetric care. 3. Conducting refresher training for health providers and monitoring the use of partographs in health facilities, and widely disseminating and monitoring implementation of the Standards for Maternal Care. 4. Implementing the referral component of the Community Strategy, including strengthening education on male involvement in birth planning and emergency preparedness. 5. Improving communication between communities and community health facilities, through provision of toll free emergency numbers. 6. Improving emergency transport between facilities by providing more ambulances, especially to service dispensaries and health centers. 7. Prioritizing the completion and implementation of the referral strategy.

23 1. Work with the University of Nairobi and other institutions that train doctors and nurses to ensure that obstetricians and gynecologists get adequate skills on fistula identification during training, and support the training of adequate numbers of surgeons. 2. Provide necessary equipment and supplies to hospitals that have trained fistula surgeons to facilitate routine repair. 3. Work with donor partners to support long-term mentoring of surgeons undergoing fistula training.

and utilization of such care in many parts of India, indicating a serious lapse in accountability.” The HRW report provides a very strong analysis of the obligations of progressive realization and the core obligations not subject to availability of resources including “establishing an accessible, transparent, and effective accountability mechanism, including monitoring, is a core obligation.” The report also quote approvingly The UN Special Rapporteur on the right to health has further observed that states also have a “core obligation” to ensure a “minimum basket of health-related services and facilities,” including “sexual and reproductive health services including information, family planning, prenatal and postnatal services, and emergency obstetric care.”

Let me cite one more case in which an NGO raised issues of surgical supplies and access to surgery as part of a human rights assessment of specific countries. Just a few days ago, the Committee on Economic, Social and Cultural Rights considered the report by Israel and information submitted by Physicians for Human Rights-Israel. The PHR report enumerated types of equipment/materials still prohibited after the improvements recorded following the flotilla raid. Among the materials defined by Israeli authorities as 'Dual Use' materials (meaning that they have both medical and military uses and current prohibited are X-Ray machines/materials, radioactive materials used for radiotherapy (cancer), PET CT scans (cancer), equipment for neurosurgery and surgery, catheterization and others. PHR list seven “central specialized areas [involving surgery that] suffer from shortage in manpower and knowledge due to de-development, lack of access to training and updates.” PHR also reports that “Israeli authorities rejected three requests between Jan and Mar 2010 of a single Palestinian delegation of ophthalmologists from the West Bank who asked to enter Gaza to carry out eye surgery because of the lack of such services in Gaza, and following rejection of requests of patients to leave Gaza for the West Bank for surgery. This damages the efforts of the Palestinian health system to develop an independent medical infrastructure and cadre of trained doctors who will lessen dependency on referrals abroad.” The report notes further that “Since June 2009, PHR-ISRAEL medical delegations from Israel have been refused access to Gaza for training of local personnel/surgery. As a result of all of these factors, the PA is obliged to refer patients to medical care outside Gaza (Israel, West Bank, Jordan, and Egypt).”

So national courts and the human rights community are raising problems of surgery in the context of human rights litigation and reporting. These isolated cases are not enough to establish REES as integral to the right to health. What then should be done to integrate REES more completely with the methods and procedures of human rights?

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26 Oncology (bone marrow transplant, radiotherapy, lab facilities s for leukemia diagnosis), Cardiology (catheterizations, bypass surgery and open heart surgery), Neurosurgery (spinal and head surgery), Neurology (nerve rehabilitation / transplant), Ophthalmology (cornea transplant, cataract care, corrections), Orthopedics (joint replacement, bone lengthening, internal fixation), General surgery (transplants, vascular surgery).
27 Ibid.
IV. MECHANISMS TO IMPLEMENT THE RIGHT TO ESSENTIAL AND EMERGENCY SURGERY

In order to change policy and the allocation of resources to implement REES, there are several elements of a strategy to be considered, some of which all into the promotion or preventive mode, others are responsive to deprivation of the right. However, before outlining these means and measures, I want to dispel a bias against treating economic, social and cultural rights, including the right to health with its surgery component as second-class rights.

Beyond the classification of ESCR as second-class rights

To the extent that surgery is a component of the right to health, the monitoring of action to give effect to the right is clearly subject to the limitations on monitoring ESCR contrasted with CPR. I submit that the authors of the article in HHR got it wrong when they said, “Although rights-based language, which originated in the realm of civil and political rights, is now familiar in the context of economic and social rights, there has been little movement on the part of governments to enact laws and ensure the realization of this latter set of rights.”28 This statement rings true for the United States if it refers to the legislation that treats health as a legally protected human right. However, much of the world has ratified the ICESCR—160 ratification to date—and there are approximately 110 national constitutions that recognize the right to health.

Indeed, some confusion might have existed in the first decades following the entry into force of the ICESCR, when little comparative research had been done on actual case law concerning ESCR. In recent decades, a vast amount of case law has been collected so as to make unsustainable the claim that justiciability attaches to CRP but not to ESCR, or not to the same degree. A recent compilation of essays documents nearly 2,000 judgments and decisions from twenty-nine national and international jurisdictions covering economic, social, and cultural rights are justiciable.29 The Special Rapporteurs on the Rights to Adequate Food, Education, and Health have established or referred to databases of case law in which the rights in question have been adjudicated. In a general comment on domestic application of the Covenant, the Committee on Economic, Social and Cultural Rights considered that the view that judicial remedies were essential for violations of CPR but not for ESCR was—not warranted either by the nature of the rights or by the relevant Covenant provisions. The Committee concluded on this point:

The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.30

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28 HHR, pp. 142-143.
So we are operating in a world where—contrary to the impressions of some and the preferences of the US government, ESCR are treated similarly with CPR, including the means and methods of implementing. These take essentially two forms, promotion and protection, corresponding roughly to preventing and curative approaches.

**Promotion of the right to essential and emergency surgery (preventive approaches)**

Means of promoting respect for human rights include education, training, dissemination of information, policy formulation, and institution building, in sum, all actions that increase the likelihood that the right will become part of social reality. Drawing from recommendations of WHO, we can outline several ways in which Ministries of Health, the health professions, and civil society might advance REES as a component of the right to health and to integrate it in health polices and programs. This is where the tools and checklists on essential surgery already development come in, as explained in the morning session by Atul Gawande. They should also be brought to the attention of human rights focal points in health ministries who can draw attention to the surgical procedures that should be part of the right to health. Each ministry should take stock and critically review the existing health and human rights professionals toolkit, which addresses advocacy, litigation, policy development, monitoring, implementation and which questions whether the existing tools are adequate or whether new ones should be developed. Of course, the WHO Integrated Management for Emergency & Essential Surgical Care e-learning toolkit seems to be the starting point for this effort. Second, the normative content of the right, derivative though it may be, is clear enough to provide guidance to governments as to what the Committee on ESCR expects of them in complying with Article 12 and for NGOs to hold them accountable. In this context it is appropriate to remind countries of national lists of essential surgery and where lacking to draw on the WHO’s GIEESC. Beyond having a suitable list, it is necessary to identify problems relating to each of the four elements of the right to health, namely, availability (which has implications for national health systems and the global burden of surgical disease), accessibility (in terms of information and affordability of essential and emergency surgery), acceptability (in term of medical ethics and cultural sensitivities) and quality of care (in terms of delivery and product quality). Each of these elements can be specified in the dialogue with States Parties.

**Good and bad practices and procedures:** Information on good practices that help to better promote and protect the right to health should be gathered from countries, international organizations, communities, and civil society organizations. Bad practices also need to be flagged. Investigating human rights violations makes it possible to ascertain the problems in policy and legislation. It is also important to look at best practices and best procedures; how are plans of action and legislative frameworks developed? Who is consulted? Better ways to consult through democratic and transparent processes with their populations over what governments and other relevant stakeholders are doing are needed.

**Legislation and policy development:** WHO recommends developing tools to assist governments, including Ministries of Health, not only to formulate policy but also to entrench human rights principles in legislation, ensuring equality in access to and quality in health services, and the other elements of the right to health mentioned above. It is necessary to go beyond policy instruments and
enshrine human rights standards into legislation and, once the law enters into force, people will be empowered to claim REES. In addition, WHO recommends reviewing existing laws, including employment, health, criminal and family law to evaluate their appropriateness in addressing health and human rights issues, which would also apply to REES. The implementation of judicial decisions is another area ripe for review. Human rights impact assessments: If a new policy is coming into force, e.g. deregulation, privatization or trade liberalization, a legitimate and fairly sober suggestion from the human rights community is that, before a policy's introduction, it should be assessed in the context of the right to health and other health-related human rights. More work is required to develop such tools, which are user-friendly and practical.

Checklists and training: Simple checklists are needed to support public health practitioners and particularly ministries of health to integrate human rights concerns in every-day work. For example, human rights work in the field has demonstrated the importance of identifying every single possible actor that can either progress or regress the right to health. Having checklists that make explicit possible duty-bearers would be useful to public health programming. Likewise, to effectively address stigma and discrimination, it could be useful to develop checklists outlining the prohibited grounds of discrimination in relation to health and how to detect such practices, as well as devising effective remedies and prevention measures.

**Protection of the right to essential and emergency surgery (curative approaches)**
Among the monitoring and accountability mechanisms that could be used to advance REES are reporting procedures, complaint procedures, and special procedures.

**Monitoring: Reporting procedures under the ICESCR and other human right treaties**
States parties to treaties containing the right to health submit reports according to guidelines for reporting. The current guidelines for reporting under the ICESCR ask governments to provide information on national health policy and on measures in eleven areas relating to the right to health, with emergency obstetric services being the only reference to surgery. The questions on the guidelines could be expanded to include other forms of emergency and essential surgery.

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31 Guidelines on Treaty-Specific Documents to be Submitted By States Parties Under Articles 16 And 17 of the International Covenant on Economic, Social and Cultural Rights, E/C.12/2008/2, 24 March 2009, paras. 55-57. The guideline for Article 12 reads: “55. Indicate whether the State party has adopted a national health policy and whether a national health system with universal access to primary health care is in place. 56. Provide information on the measures taken to ensure: (a) That preventive, curative, and rehabilitative health facilities, goods and services are within safe reach and physically accessible for everyone, including older persons and persons with disabilities; (b) That the costs of health-care services and health insurance, whether privately or publicly provided, are affordable for everyone, including for socially disadvantaged groups; (c) That drugs and medical equipment are scientifically approved and have not expired or become ineffective; and(d) Adequate training of health personnel, including on health and human rights. 57. Provide information on the measures taken: (a) To improve child and maternal health, as well as sexual and reproductive health services and programmes, including through education, awareness-raising, and access to family planning, pre- and post-natal care and emergency obstetric services, in particular in rural areas and for women belonging to disadvantaged and marginalized groups; (b) To prevent, treat and control diseases linked to water and ensure access to adequate sanitation; (c) To implement and enhance immunization programmes and other strategies of infectious disease control; (d) To prevent the abuse of alcohol and tobacco, and the
In addition, NGOs can raise the issue in shadow reports when relevant country reports are considered.

Accountability for violations: Complaints procedures under human rights treaties

In a case decided by the Committee against Torture, an Azeri national sentenced to death on 24 August 1994 by the Supreme Court of Azerbaijan. On 10 February 1998, all death sentences handed down in Azerbaijan, including the complainant’s, were commuted to life imprisonment, following the abolition of the death penalty by Parliament. The complainant claims to be a victim of violation by Azerbaijan of his rights under articles 1, 2, 12 and 13. According to the complaint ill prisoners allegedly were held together with other prisoners, surgery was made in inadequate conditions and several prisoners died because of bad medical care. More complaints of this nature before various treaty bodies will generate precedents for treating REES and integral not only to the right to health but also to the rights to life, and to prohibition of cruel inhuman or degrading punishment or treatment.

Accountability for violations: the role of special procedures

There are a few cases in which surgery has been a matter of concern for UN special procedures handling situations and cases of human rights violations. For example, the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya, handled a case concerning the death in detention of Mr. Novruzali Mammadov, Head of the Talysh Cultural Centre, editor of now-defunct Talysh minority language newspaper, Talyshi Sado (Voice of the Talysh) and a Talysh language expert. Ms. Sekaggya learned on 17 August 2009 that Mr. Mammadov died in detention at the hospital of the Ministry of Justice's Penitentiary Service in Baku, Azerbaijan, where he had been transferred on 27 July 2009. She details in her report: “Mr. Mammadov’s serious health condition reportedly required urgent surgery. However, prison authorities allegedly failed to provide him with adequate medical treatment, as reported by his family who was allowed to visit him on 30 July. Moreover, in the days prior to his death, and despite his alleged aggravated condition and pain, Mr. Mammadov was placed in a common ward, lacking sanitary facilities and bed clothing.” She noted, “Grave concern was expressed that the lack of sufficient medical care and deplorable conditions of detention may have aggravated Mr. Mammadov’s health condition leading to his death.” The Government claimed that the information about the physical and psychological pressure on Mammadov was inaccurate and that the forensic medical examination revealed no injuries on his body. The Special Rapporteur reminded the Government of the provisions of the

33 A/HRC/13/22/Add.1, 24 February 2010, para. 96.
34 Id., para. 97.
35 Id., para 98.
Declaration on human rights defenders, relating to the right to information about human rights and the right to publish, but not the right to health, including essential surgery. 36

Health professionals, health agencies, and health development NGOs can use existing human rights mechanisms more effectively to heighten accountability for health. Urgent appeals on cases of alleged violations of the right to health and health-related rights can be put forward to the UN Special Rapporteur on the right to health and other relevant monitoring mechanisms. In terms of monitoring, moreover, more work is needed to develop common indicators for the monitoring of the right to health and, more broadly, indicators for human rights-based programming in health.

V. CONCLUSION
Two overriding issues will determine the future of REES, political will and clarification of resource implications.

Mobilization of political will
Three human rights have recently been acknowledged as being either integral to the right to health or closely allied to it. In each case, the affected populations successfully mobilized political support to use human rights machinery in new ways. Recently, the right to essential medicines was the object of a Human Rights Council resolution (12/24) sponsored by Brazil and building on the activism of groups like MSF. A few weeks ago I participated in a consultation of governments, NGOs and experts in Geneva in application of that resolution, where the political will was manifest by Brazil, MSF and others. Similarly, the case for a human right to tobacco control, which a thoracic surgeon and I made in an article in Human Rights Quarterly, is promoted through a number of recent initiatives, such as the Human Rights and Tobacco Control Network, which builds on the enormous mobilization around this issue, whether the Tobacco Free Initiative or the FCTC and the Tobacco Control Alliance

We do not have a similar politically significant mobilization around REES. REES needs its Brazil and MSF. Perhaps this conference will be the starting point.

Resources
The second conclusion has to do with resources. Critical to the claim that REES can be part of a realizable human right is its economic feasibility, which in turn is dependent upon overcoming the widely held perception that it is too expensive and complex, especially in resource-limited settings. The two major elements in determining its cost-effectiveness are level of training of surgeons and attendants and expensive equipment for both transportation and the OR. Of course the right to essential medicines, as already discussed, has been very much related to imposing affordability either through differential pricing, aid from foundations or the Global Fund, compulsory licensing or parallel importing of generics. But even when prices are kept low, in the case of chronic diseases, which AIDS is becoming, the cost over time is likely to be greater that a one-time surgical operation that saves or markedly improves a life. Surgical task shifting seems to be a promising

36 Id., para. 102.
way of reducing costs. The examples we have heard about efforts to make pulse oximeters available in developing countries at affordable prices support the argument that resources are not an insurmountable obstacle to REES.

What is truly fascinating is that my very superficial observation is that human rights activists and scholars, who often cannot encounter a new right they don’t like, tend to be reserved when it comes to surgery, invoking the basic obligation of the ICESCR that these rights—including the right to health—are to be implemented progressively in accordance with available resources. The UN Special Rapporteur on the right to health is exceptional in this regard when he considered that emergency obstetric care as part of the state’s “core obligations” to ensure a “minimum basket of health-related services and facilities,” and therefore not subject to availability of resources but must be immediately realized. He would probably not extend the core obligation much beyond emergency obstetric care and many others would even consider that states should aspire to reach that standard of care but are not bound unless and until resources are adequate. Surgeons, on the other hand – and not just Kelly and her co-authors – are quick to point out the cost effectiveness of essential and emergency surgery and to document the longer term economic advantages of including RESS with the right to health. They thus conclude with McQueen et al “the basic right to health care demands the delivery of essential surgical services.”

So we have a way to go before REES joins the rights to water, to essential medicines, and tobacco control, as integral to the right to health, but the reasoning is the same. That assertion does not detract from the main point made by McQueen et al that “considering essential and emergency surgery as a human right is a reasonable position” and that the obligation to make the right to health available includes “certain types of surgery that prevent significant morbidity and mortality at low cost should also be included within this framework of public health services.” That is a conclusion, which I invite you all to share.

38 McQueen, et al., p. 147.
39 Id., p. 143-144.