Abstract

We propose a methodology to evaluate fulfillment of the human right to health, using eight health indicators as proxies. Each health indicator was plotted against purchasing power parity US$ gross domestic product (GDP)/capita to control for wealth. Generalized linear regression was used to derive a "best fit" curve. An "expected" value for each variable was calculated based on the GDP/capita of each country. The observed (reported) value was then divided by the "expected" value to give a score for that variable. Scores for each variable were averaged to give an overall health-related human rights score for each country. We believe that this report card is an initial step in the development of an effective means of monitoring health and human rights and can become a useful tool to quantify the fulfillment of the right to health. We invite comment on the approach.

Nous proposons une méthodologie pour évaluer l'application des droits de l'homme à la santé en utilisant huit indicateurs de santé comme repères témoins. Chaque repère est positionné par rapport à la parité de pouvoir d'achat relatif au produit intérieur brut américain (PIB) par habitant utilisé comme valeur de référence de richesse. Une régression linéaire généralisée à été utilisée pour calculer une courbe optimale. Une valeur "attendue" a été calculée pour chaque variable en se basant sur le PIB par habitant pour chaque pays. La valeur observée (déclarée) a alors été divisée par la valeur "attendue" pour donner une note à cette variable. La moyenne des notes de chaque variable a été faite afin de donner une note globale des droits de l'homme concernant la santé pour chaque pays. Nous pensons que ce carnet de notes est une étape initiale vers le développement de moyens efficaces pour aboutir au suivi de la santé et des droits de l'homme et peut s'avérer être un outil utile pour quantifier le droit à la santé. Nous invitons vos commentaires sur cette approche.

Proponemos una metodología para evaluar la satisfacción del derecho humano a la salud, al usar ocho indicadores de salud como medios para evaluar la satisfacción de derechos. Cada indicador de salud se graficó contra el producto interno bruto (PIB) con paridad de dólares estadounidenses para el poder adquisitivo per cápita para tomar en cuenta la riqueza. Se usó regresión lineal generalizada para calcular la curva de "mejor ajuste". Se calculó un valor "esperado" para cada variable con base en el PIB per cápita de cada país. El valor observado (informado) después se dividió por el valor "esperado" para obtener una puntuación para esa variable. Las puntuaciones para cada variable se promediaron a fin de obtener una puntuación de derechos humanos relacionados con la salud mental para cada país. Creemos que esta tarjeta es un paso inicial en la creación de un medio eficaz para vigilar y regular los derechos de salud y humanos, y puede convertirse en un recurso útil para cuantificar la satisfacción del derecho a la salud. Invitamos al lector a comentar el método.

MAKING THE GRADE: A First Attempt at a Health and Human Rights Report Card

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In the past decade much has been written about the field of health and human rights and the practical applications of a human rights framework.[1] Health is understood as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] Human rights are understood as an arm of international law that includes the United Nations Charter, the 1948 Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and many other international declarations, covenants, and conventions.[3] Human rights describe the rights of the individual vis-à-vis the state (government) and the state's obligation to respect, protect, and fulfill those rights.

Mann et al., outlined three key relationships between health and human rights:

- the impact of health policies and programs on human rights;
- the impact of human rights abuses on health; and

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- the "inextricable linkage" between health and human rights as "complementary approaches to the central problem of defining and advancing human well being."[4]

Human rights conventions allow for limitations on many rights based on certain grounds, one of which is public health. Public health programs and policies are developed and implemented through governmental agencies, thus making public health professionals state actors. For these reasons, public health professionals have a special obligation to plan public health policies and programs with an awareness of human rights.

Violations of human rights can negatively affect health. The failure of states to respect rights such as the right to be free from arbitrary detention or torture may have a direct link to the health status of an individual. Indirect health impacts may occur as a result of a state's failure to fulfill economic, social, and cultural rights. Multiple rights may be violated at the same time.

In 2002, the United Nations Commission on Human Rights appointed a "Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health" (Special Rapporteur). The mandate of the Special Rapporteur includes identifying mechanisms with which to measure the fulfillment of the right to health as outlined in the human rights corpus. In his October 2003 interim report to the United Nations General Assembly, the Special Rapporteur suggests a possible framework for measuring the fulfillment of the right to health. This framework defines a right to health indicator as a health indicator that is explicitly derived from specific right to health norms and proposes that the monitoring of the indicator will be used to hold duty bearers to account.[5] The Special Rapporteur suggests three categories of right to health indicators: structural, process, and outcome. Building on the approaches taken by UNICEF and the Human Development Index (HDI), we propose a tool to measure the health-specific realization of human rights. The tool, the Health and Human Rights Report Card, includes measures of right to health indicators in all three of the proposed categories (two structural, two process, and four outcome).[6,7]

Methods

Three major steps were taken to develop the Health and Human Rights Report Card:

1) Review of Major Human Rights Documents to Identify Provisions Related Directly to Health

The major human rights document referring to the right to health is the International Covenant on Economic, Social, and Cultural Rights (ICESCR).

The right to health is most explicitly defined in Article 12 of the ICESCR, which states:

> 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. 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:
>
> - The provision for the reduction of the stillbirth-rate and of infant mortality and for the development of the child;
> - The improvement of all aspects of environmental and industrial hygiene;
> - The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases;
> - The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[8]

Many other international and regional documents make mention of the "right to health." In addition, the preamble of the World Health Organization (WHO) Charter states that, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition."[9] Article 25.1 of the Universal Declaration of Human Rights (UDHR) states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or lack of other livelihood in circumstances beyond his control. [10]

According to WHO, every nation state is a party to at least one international convention that addresses health-related

rights.[11] States may not have the capability to fully uphold all rights at any given time, but all have an obligation to work toward progressive realization of rights and to report on that realization. Specific health indicators relevant to this project mentioned in the "Guidelines for Reporting on Article 12 of the ICESCR" include infant mortality rate; infant immunization rates; life expectancy; proportion of pregnant women having access to trained personnel during pregnancy and the proportion attended by such personnel for delivery; and proportion of infants having access to trained personnel for care.[12]

2) Identification of Health Indicators to Use As Proxies for Rights Fulfillment

Eight health indicators were selected as proxies for the fulfillment of the right to health. The indicators were taken from the World Bank *2004 World Development Indicators*, which contains officially reported data (including more than 500 variables) for 208 countries.[13] Health variables were chosen that we determined could be directly correlated to the "right to health" as specified in the human rights documents and that were reported by a high proportion of countries. Table 1 outlines the health-related right and the specific health indicator within the 2004 World Development Indicators dataset chosen to measure its fulfillment.

Country data published on the *2004 World Development Indicators* CD-Rom were used for the most current year available (2000–2003).[14] The data for every country in the dataset were selected for each of the following variables:

- *Purchasing Power Parity in US Dollars (PPP) gross domestic product (GDP) per capita*: number of units of a country's currency required to buy the same number of goods and services in the domestic market as a US dollar would buy in the United States;
- *Adult (15–60 years) male mortality rate (per 1,000):* probability of a male dying between the ages of 15 and 60—that is, the probability of a 15-year-old dying before reaching age 60 — if subject to current age-specific mortality rates between ages 15 and 60. This variable was chosen because male mortality rates are higher than those of females;
- *Health expenditures as percent of GDP:* public health expenditures, consisting of recurrent and capital

Health-Related Human Right	Indicator(s)	Indicator Type	Number of Countries Reporting
The right of everyone to "the enjoyment of the highest attainable standard of physical and mental health" (ICESCR)	Adult mortality rate for males	Outcome	193
The right of everyone to a "standard of living adequate for the health and well-being of himself and of his family, including food…medical care…" (UDHR)	Health expenditures as percent of GDP	Structural	185
	Access to prenatal care	Process	116
The rights of mothers and children to "special care and assistance" (UDHR and ICESCR)	Percent of births attended by trained staff	Structural	159
	Percent of children immunized against diphtheria, tetanus, and pertussis	Process	186
The right to "reduction of the stillbirth-rate and of infant mortality" (ICESCR)	Infant mortality rate	Outcome	189
The right of everyone "to education" (UDHR)	Net primary school female enrollment ratio	Structural	143
The right of everyone to "improvement of all aspects of environmental and industrial hygiene" (ICESCR)	Percent access to potable water	Outcome	145

Table 1. *Health-related human rights and indicators of those rights.*

spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds;

- *Access to prenatal care*: percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy;
- *Births attended by skilled health staff:* percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period, to conduct deliveries on their own, and to care for newborns;
- *Immunization against diphtheria, tetanus, and pertussis (three doses) of 12-to-23-month-old children*: percentage of children ages 12–23 months who received

vaccinations before 12 months of age or at any time before the survey. A child is considered adequately immunized against diphtheria after receiving three doses;

- *Infant mortality rate (per 1,000 live births):* number of infants dying before reaching one year of age, per 1,000 live births in a given year;
- *Net primary school female enrollment (proportion of school-age females who are enrolled in school):* ratio of the number of children of official school age (as defined by the national education system) who are enrolled in school to the population of the corresponding official school age. Education has been linked to health status, and females were selected because of their likelihood of being excluded from education on the basis of their sex;
- *Access to potable water*: percentage of the population with reasonable access to an adequate amount of water from an improved source, such as a household connection, public standpipe, borehole, protected well or spring, or rainwater collection. Reasonable access is defined as the availability of at least 20 liters per person per day from a source within one kilometer of the dwelling. [15]

3) Development of a Measuring Stick to Assess the Degree of Fulfillment of These Rights.

Although human rights are not in and of themselves resource dependent, fulfillment for many is dependent on the level of development in a country, and there is explicit recognition of the need for progressive realization. It would be unrealistic to expect a developing country to have attained the same realization of a resource-dependent right as a wealthier nation. For this reason, each indicator was plotted against PPP US$ GDP/capita to control for wealth. Using PPP makes this analysis more familiar to those in the human rights field, many of whom are accustomed to reading reports by UNICEF and UNDP, which use this metric.[16,17]

Data were exported to an Excel spreadsheet and then exported to SAS for regression analysis, at which point the natural log of GDP/capita was calculated, creating a new, transformed independent variable. Each Y variable (for example, infant mortality) was plotted against GDP/capita (the X variable), using standard SAS procedures. A linear, cubic, or

quadratic regression line was fit to the scatter plot, with one of these three chosen based on which provided the best visual fit. A 95% prediction interval based on individual observations was overlaid on this plot, using standard SAS procedures. As an example, Figure 1 displays the values for potable water along with the best fit curve and the upper and lower 95% prediction intervals based on the regression analysis.

The second step in data analysis was the calculation of an "expected" value for each variable based on the GDP/capita of that country, using the upper limit of the 95% prediction interval (or the lower limit, if a low value is the desired outcome). The observed (reported) value was then divided by the "expected" value to give a score for that variable. If the observed value was greater than the expected, the score was capped at 1.00. For variables in which a lower value is desired (for example, infant mortality) the reciprocal of the observed/expected ratio was used for the score. Since zero mortality rates are not possible, the lower limits of expected mortality rates were taken as the lowest observed rate in any country.

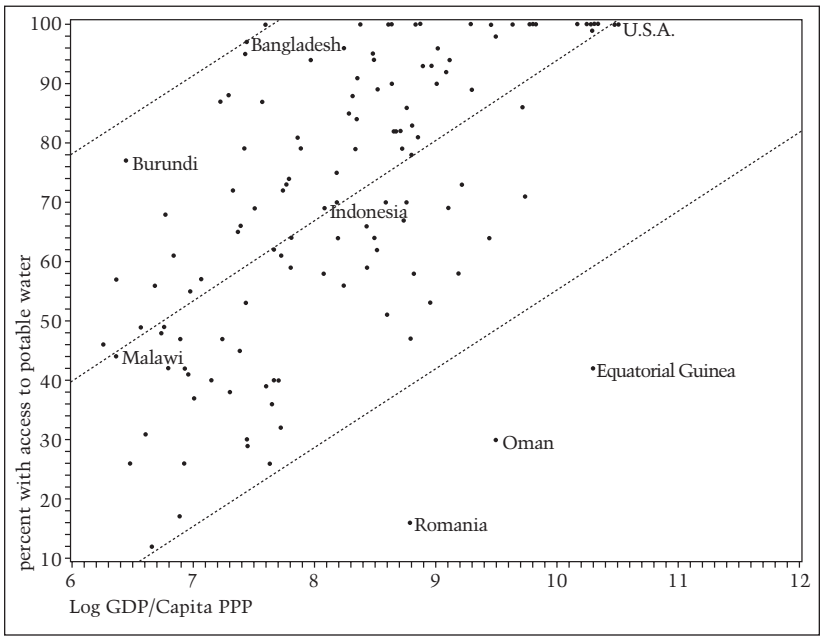

Figure 1. *Percent access to potable water by country and Purchasing Power Parity GDP per capita in US dollars.*

Individual ratio scores for each variable were added together and divided by the number of variables reported to give an overall health-related human rights indicator score (summary ratio), with a minimum value of 0 and a maximum value of 1.00. Individual indices were not weighted, primarily because any weighting scheme proposed would appear to be arbitrary.

Twenty-seven countries were missing data for the GDP variable and were excluded from analysis. Forty percent of the remaining countries had data for all eight indicators; 85% had data for at least six indicators. Thus, the Health and Human Rights Report Card was calculated for 181 countries using these variables.

Results

Table 2 shows the 10 highest and 10 lowest scoring countries for which there were data on seven or more indices. Figure 2 depicts all 181 countries that reported GDP data and their overall scores by PPP US$ GDP/capita. For purposes of illustration, several countries are identified. Table 3 lists the summary score for each of the 181 countries as well as the number of variables reported.

Country	Average	Country	Average
Moldova	0.886	Nigeria	0.45
Canada	0.882	Cameroon	0.427
Netherlands	0.873	Angola	0.423
Australia	0.871	Guinea	0.419
Finland	0.869	Cambodia	0.412
United Kingdom	0.862	Lao PDR	0.408
New Zealand	0.843	Burkina Faso	0.401
Slovenia	0.842	Chad	0.387
Austria	0.816	Niger	0.373
United States	0.815	Ethiopia	0.347

Table 2. *Ten highest and lowest scoring countries using summary ratio of health and human rights indicators. (Countries reporting less than seven of the eight indicators were not included.)*

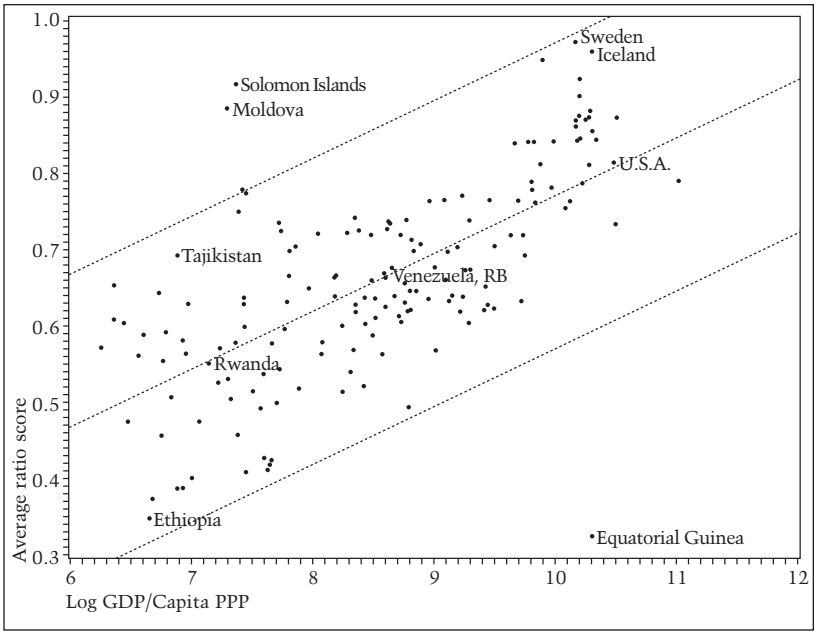

Figure 2. *Summary health and human rights score, by country and Purchasing Power Parity GDP per capita in US dollars.*

Country Name	Average	Std. Dev.	# Indicators
Afghanistan	*	*	missing GDP
Albania	0.7191	0.3529	8
Algeria	0.6763	0.2962	8
American Samoa	*	*	missing GDP
Andorra	*	*	missing GDP
Angola	0.4234	0.1712	7
Antigua and Barbuda	0.6740	0.3321	6
Argentina	0.7386	0.3149	7
Armenia	0.7210	0.2605	7
Aruba	*	*	missing GDP
Australia	0.8707	0.1750	8
Austria	0.8815	0.1677	7
Azerbaijan	0.5635	0.3279	8
Bahamas, The	0.6321	0.3506	6
Bahrain	0.6925	0.3321	6
Bangladesh	0.5990	0.0386	8
Barbados	0.0718	0.2959	7
Belarus	0.7271	0.3742	7
Belgium	0.7875	0.1747	6
Belize	0.6130	0.3294	7
Benin	0.6288	0.1539	7
Bermuda	*	*	missing GDP
Bhutan	*	*	missing GDP
Bolivia	0.6659	0.2060	8
Bosnia and Herzegovina	*	*	missing GDP

Table 3. *Summary ratios for health and human rights indicators for 208 countries (continued on following pages).*

Country Name	Average	Std. Dev.	# Indicators
Botswana	0.6768	0.3848	8
Brazil	0.6357	0.3311	8
Brunei	*	*	missing GDP
Bulgaria	0.6658	0.3352	6
Burkino Faso	0.4005	0.0911	8
Burundi	0.6038	0.2157	8
Cambodia	0.4117	0.1981	8
Cameroon	0.4268	0.1910	7
Canada	0.8821	0.1499	7
Cape Verde	0.6362	0.3281	7
Cayman Islands	*	*	missing GDP
Central African Republic	0.4748	0.1233	7
Chad	0.3875	0.1168	8
Channel Islands	*	*	missing GDP
Chile	0.7035	0.2699	8
China	0.6370	0.3038	8
Colombia	0.6559	0.2810	8
Comoros	0.6370	0.2504	6
Congo, DR	0.4751	0.1338	7
Congo, Rep.	0.3868	0.1324	5
Costa Rica	0.7657	0.2216	8
Cote d'Ivoire	0.5042	0.2353	8
Croatia	0.7711	0.2822	5
Cuba	*	*	missing GDP
Cyprus	0.7891	0.2119	6
Czech Republic	0.8398	0.1930	6
Denmark	0.8443	0.1645	5
Djibouti	0.5371	0.3276	6
Dominica	0.7342	0.2990	7
Dominican Republic	0.6463	0.3423	8
Ecuador	0.6388	0.2596	8
Egypt, Arab Rep.	0.6001	0.3146	8
El Salvador	0.5874	0.2662	8
Equatorial Guinea	0.3236	0.2609	6
Eritrea	0.5918	0.2073	8
Estonia	0.6206	0.3483	5
Ethiopia	0.3473	0.1612	8

Country Name	Average	Std. Dev.	# Indicators
Faeroe Islands	*	*	missing GDP
Fiji	0.6248	0.3430	7
Finland	0.8692	0.1838	8
France	0.8760	0.1641	6
French Polynesia	*	*	missing GDP
Gabon	0.4932	0.3287	8
Gambia, The	0.6285	0.2126	8
Georgia	0.7355	0.2406	8
Germany	0.8459	0.1926	4
Ghana	0.5771	0.1904	8
Greece	0.7625	0.1444	5
Greenland	*	*	missing GDP
Grenada	0.7071	0.3553	6
Guam	*	*	missing GDP
Guatemala	0.5394	0.2946	8
Guinea	0.4186	0.1550	8
Guinea-Bissau	0.5605	0.1338	7
Guyana	0.6184	0.3691	6
Haiti	0.4659	0.1776	7
Honduras	0.7050	0.1841	8
Hong Kong, China	0.9021	0.1385	2
Hungary	0.7046	0.3150	6
Iceland	0.9600	0.0398	5
India	0.5183	0.2379	8
Indonesia	0.5792	0.2905	8
Iran, Islamic Rep.	0.6211	0.3098	7
Iraq	*	*	missing GDP
Ireland	0.7333	0.1960	5
Isle of Man	*	*	missing GDP
Israel	0.8127	0.1989	5
Italy	0.8431	0.1247	5
Jamaica	0.7221	0.2960	8
Japan	0.9237	0.1007	6
Jordan	0.7419	0.3199	8
Kazakhstan	0.6395	0.3861	8
Kenya	0.5814	0.1886	8
Kiribati	*	*	missing GDP

Country Name	Average	Std. Dev.	# Indicators
Korea, Dem. Rep.	*	*	missing GDP
Korea, Rep.	0.7189	0.2719	7
Kuwait	0.7644	0.2582	7
Kyrgyz Republic	0.7500	0.2471	8
Lao PDR	0.4084	0.1996	8
Latvia	0.6332	0.3744	6
Lebanon	0.7254	0.3343	7
Lesotho	0.6316	0.2848	8
Liberia	*	*	missing GDP
Libya	*	*	missing GDP
Liechtenstein	*	*	missing GDP
Lithuania	0.6384	0.3203	5
Luxembourg	0.7902	0.2055	6
Macao, China	0.9492	0.0880	3
Macedonia,	0.7390	0.3500	5
Madagascar	0.5880	0.1698	8
Malawi	0.6532	0.1913	7
Malaysia	0.6976	0.3225	7
Maldives	*	*	missing GDP
Mali	0.5065	0.1188	7
Malta	0.8418	0.1639	6
Marshall Islands	*	*	missing GDP
Mauritania	0.4990	0.2063	8
Mauritius	0.6040	0.3711	6
Mayotte	*	*	missing GDP
Mexico	0.6604	0.3069	8
Micronesia, Fed, Sts.	*	*	missing GDP
Moldova	0.8856	0.2114	8
Monaco	*	*	missing GDP
Mongolia	0.7745	0.2771	8
Morocco	0.5139	0.2737	8
Mozambique	0.5638	0.2057	8
Myanmar	*	*	missing GDP
Namibia	0.6051	0.3291	8
Nepal	0.5254	0.2671	8
Netherlands	0.8734	0.1614	7
Netherlands Antilles	*	*	missing GDP
New Caledonia	*	*	missing GDP
New Zealand	0.8427	0.1781	7
Nicaragua	0.6983	0.1347	8
Niger	0.3734	0.1495	8
Nigeria	0.4560	0.1663	7
Northern Mariana Islands	*	*	missing GDP
Norway	0.8735	0.1157	6
Oman	0.6225	0.3216	8
Pakistan	0.4919	0.2489	8
Palau	*	*	missing GDP
Panama	0.7192	0.2644	8
Papua New Guinea	0.5428	0.2023	8
Paraguay	0.6026	0.2619	8
Peru	0.6106	0.2962	8
Philippines	0.5686	0.3081	8
Poland	0.6729	0.3121	5
Portugal	0.7787	0.2297	5
Puerto Rico	0.7635	0.3344	2
Qatar	*	*	missing GDP
Romania	0.6196	0.3934	7
Russian Federation	0.5677	0.3920	5
Rwanda	0.5509	0.2732	7
Samoa	0.7360	0.3532	7
San Marino	*	*	missing GDP
Sao Tome and Principe	*	*	missing GDP
Saudi Arabia	0.6272	0.2853	8
Senegal	0.5782	0.1248	8
Serbia and Montenegro	*	*	missing GDP
Seychelles	*	*	missing GDP
Sierra Leone	0.5716	0.1257	7
Singapore	0.7548	0.3518	5
Slovak Republic	0.7651	0.2799	7
Slovenia	0.8417	0.1886	7

Country Name	Average	Std. Dev.	# Indicators
Solomon Islands	0.9172	0.2706	6
Somalia	*	*	missing GDP
South Africa	0.6186	0.3485	8
Spain	0.7819	0.1834	5
Sri Lanka	0.6639	0.3104	7
St. Kitts and Nevis	0.6517	0.3869	6
St. Lucia	0.5626	0.3161	5
St. Vincent and Grenadine	0.6636	0.3696	6
Sudan	0.5143	0.2538	7
Suriname	*	*	missing GDP
Swaziland	0.5213	0.3410	7
Sweden	0.9725	0.0409	6
Switzerland	0.8557	0.1542	6
Syrian Arab Republic	0.6662	0.3000	8
Tajikistan	0.6920	0.2711	8
Tanzania	0.6083	0.1612	8
Thailand	0.6456	0.3302	8
Timor-Leste	*	*	missing GDP
Togo	0.5307	0.2001	8
Tonga	0.6982	0.3374	7
Trinidad and Tobago	0.6398	0.3527	7
Tunisia	0.7129	0.2957	8
Turkey	0.6310	0.2962	7
Turkmenistan	0.6278	0.4108	6
Uganda	0.5708	0.2210	7
Ukraine	0.6600	0.3590	7
United Arab Emirates	*	*	missing GDP
United Kingdom	0.8621	0.1567	7
United States	0.8147	0.2315	7
Uruguay	0.7638	0.2866	8
Uzbekistan	0.7790	0.2248	7
Vanuatu	0.6493	0.2645	7
Venezuela, RB	0.6688	0.2777	8
Vietnam	0.7252	0.2002	8
Virgin Islands (US)	*	*	missing GDP
West Bank and Gaza	*	*	missing GDP
Yemen, Rep.	0.5541	0.2354	7
Zambia	0.6432	0.2015	8
Zimbabwe	0.5958	0.2652	8

Discussion

This initial effort to develop a health and human rights report card attempts to strike a balance among so-called structural, process, and outcome measures, with an emphasis on outcome. One of the primary strengths of this approach is its simplicity. Since the approach uses data reported by nation states, there is less likelihood that the data may be challenged if the results are unflattering. On the other hand, because these data are self-reported, it is also true that they may not be an accurate reflection of the actual health situation.

A major potential weakness of the report card would be if the indicators chosen did not adequately reflect realization of the particular right. We believe that the indicators chosen are reasonable, even as there may be other indicators that might serve as well or better. A problem is that, for

many potential indicators (for example, access to family planning services), there are so many countries not reporting data that there would not be adequate representation in the summary totals. Eighty-five percent of countries reporting GDP/capita reported on at least six of the eight indicators we used. Another limitation is that these data are reported on the national level and thus will not reflect regional or sub-population variation. If these data were available in a given country, the approach could be used to compare sub-populations.

An additional methodological issue is the fact that data analysis was limited to the most recent year available for a given country (2000–2003), and thus a fixed point in time comparison is not possible. Furthermore, the predicted value is based on the upper (or lower) 95% prediction interval trend line created in regression analysis; thus, in a few cases the ratio scores for some variables were greater than one (or less than zero). Ratio scores were capped at one (or minimum observed).

Even with the shortcomings noted above, we believe that a health and human rights report card can assist health professionals, human rights advocates, policy-makers, United Nations officials, and governments by providing:

- A useful means of assessing the status of a given country with respect to health and human rights;
- A means of comparing the health and human rights status of one country with respect to other countries;
- A basis for rights-sensitive program planning and evaluation; and
- A basis for advocacy and public education, including raising awareness about the right to health among the general population and among public health and medical professionals.

The score can be understood as a summary of the fulfillment of the range of health and human rights indicators used in this exercise. Individual health indicators can also be looked at to make comparisons on the issues between individual countries.

Using specific health indicators to calculate the Health and Human Rights Report Card allows public health profes-

sionals and policy-makers to recognize specific health areas that need attention in order to improve the realization of health-related human rights. Thus, the Health and Human Rights Report Card can encourage changes in domestic policy to enhance the fulfillment of rights.

The Global Equity Gauge Alliance (GEGA) is another attempt to create a content-specific measure of the equitable distribution of health goods, services, and programs. GEGA utilizes a variety of methods, including household surveys and focus groups, for the collection of data within 13 countries. [18] In contrast, and similar to the HDI, the report card approach utilizes self-reported primary international data sources.[19] While some of the indicators utilized here are similar to those of the HDI in addressing mortality (or life expectancy) and education, we believe that our selected indicators address a broader range of health-specific issues from a standardized data source, making it distinct in methodology and substance from the approaches taken by both GEGA and HDI. We believe that this approach provides a more complete (albeit still selective) picture of the fulfillment of health-related human rights on which states must focus their attention. In this respect, the report card approach might be viewed as the other side of violations approaches by highlighting priority areas on which states must focus their attention.[20]

Of additional interest is the way in which countries are distributed on the health and human rights index. Some industrialized countries are among the lowest scoring countries, while some developing countries are among the highest scoring countries on the scale, suggesting that, given their resources, these countries are better providing for the health needs of the population than many countries with more developed economies. This indicates a rich area for future research.

Conclusion

The fulfillment of human rights in general, and the right to health in particular, are lofty goals. They are also obligations held by states to respect and uphold human dignity and human potential. The Health and Human Rights Report Card represents a step toward being able to quantify

the fulfillment of the right to health. This tool utilizes the strength of public health epidemiological and statistical data in combination with the human rights framework to bring together the fields of health and human rights.

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