

# CODES OF ETHICS AND DECLARATIONS RELEVANT TO THE HEALTH PROFESSIONS

FIFTH EDITION

An Amnesty International  
compilation of selected ethics  
and human rights texts and  
other international standards

AMNESTY  
INTERNATIONAL



CODES OF ETHICS AND DECLARATIONS  
RELEVANT TO THE HEALTH PROFESSIONS

**AMNESTY INTERNATIONAL IS A GLOBAL MOVEMENT OF 2.2 MILLION PEOPLE IN MORE THAN 150 COUNTRIES AND TERRITORIES WHO CAMPAIGN TO END GRAVE ABUSES OF HUMAN RIGHTS. OUR VISION IS FOR EVERY PERSON TO ENJOY ALL THE RIGHTS ENSHRINED IN THE UNIVERSAL DECLARATION OF HUMAN RIGHTS AND OTHER INTERNATIONAL HUMAN RIGHTS STANDARDS. WE ARE INDEPENDENT OF ANY GOVERNMENT, POLITICAL IDEOLOGY, ECONOMIC INTEREST OR RELIGION – FUNDED MAINLY BY OUR MEMBERSHIP AND PUBLIC DONATIONS.**

**[www.amnesty.org](http://www.amnesty.org)**

# **CODES OF ETHICS AND DECLARATIONS RELEVANT TO THE HEALTH PROFESSIONS**

AN AMNESTY INTERNATIONAL COMPILATION OF  
SELECTED ETHICS AND HUMAN RIGHTS TEXTS  
AND OTHER INTERNATIONAL STANDARDS

**AMNESTY**  
INTERNATIONAL



Fifth edition first published in 2009 by  
Amnesty International Publications  
International Secretariat  
Peter Benenson House  
1 Easton Street  
London WC1X 0DW  
United Kingdom  
[www.amnesty.org](http://www.amnesty.org)

© Copyright Amnesty International Publications 2009  
ISBN: 978-0 86210-445-0  
Index: ACT 75/001/2009

All rights reserved. This publication is copyright, but may be reproduced by any method without fee for advocacy, campaigning and teaching purposes, but not for resale. The copyright holders request that all such use be registered with them for impact assessment purposes. For copying in any other circumstances, or for re-use in other publications, or for translation or adaptation, prior written permission must be obtained from the publishers, and a fee may be payable.

Amnesty International gratefully acknowledges the following organizations for permission to reproduce their material: the International Federation of Gynecology and Obstetrics (FIGO) for Ethical Aspects of HIV Infection and Reproduction; Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights; Resolution on Female Genital Mutilation; Resolution on Violence Against Women; Resolution on Women's Rights Related to Reproductive and Sexual Health; Resolution on Women's Sexual and Reproductive Rights – A Social Responsibility for Obstetricians and Gynaecologists. The International Council of Nurses for Position Statement on Nurses and Human Rights; Position Statement on the Elimination of Female Genital Mutilation; Position Statement on the Nurse's Role in the Care of Detainees and Prisoners; Torture, Death Penalty and Participation by Nurses in Executions. The Council for International Organizations of Medical Sciences for Guidelines for Biomedical Research © CIOMS. The World Confederation for Physical Therapy for Declaration of Principle – Torture. Amnesty International has requested permission from all other organizations which hold copyright for texts cited and gratefully acknowledges their support.

# CONTENTS

LIST OF AUTHORS OF CODES AND DECLARATIONS

LIST OF CODES AND DECLARATIONS

GLOSSARY OF ACRONYMS

INTRODUCTION 1

CODES OF ETHICS AND DECLARATIONS BY THEME

1/ANCIENT OATHS	3
2/ARMED CONFLICT	5
3/BIOMEDICAL RESEARCH	8
4/CHILDREN	77
5/DEATH PENALTY	108
6/DEVELOPMENT	114
7/DISABILITY	126
8/DISAPPEARANCES	150
9/DISCRIMINATION	170
10/DUAL LOYALTIES	171
11/EXTRAJUDICIAL EXECUTIONS	179
12/FEMALE GENITAL MUTILATION	186
13/HIV AND AIDS	194
14/HUMAN RIGHTS (GENERAL)	226
15/HUNGER STRIKES	254
16/MENTAL ILLNESS	258
17/PRISONERS AND PRISON SETTINGS	280
18/PROFESSIONAL ETHICAL CODES	323
19/RIGHT TO HEALTH	339
20/SEXUAL AND REPRODUCTIVE RIGHTS	383
21/TORTURE	391
22/TRANSPLANTATION	424
23/WOMEN'S HUMAN RIGHTS	445
ENDNOTE	484

## LIST OF AUTHORS OF CODES AND DECLARATIONS

Amnesty International  
Committee on Economic, Social and Cultural Rights  
Council for International Organizations of Medical Sciences  
Geneva Conventions  
International Confederation of Midwives  
International Conference on Primary Health Care  
International Council of Nurses  
International Council of Prison Medical Services  
International Dual Loyalty Working Group  
International Federation of Gynecology and Obstetrics  
International Military Tribunal  
International Summit on Transplant Tourism and Organ Trafficking  
International Union of Psychological Science  
Istanbul Protocol  
Joint United Nations Programme on HIV/AIDS/Office of the  
    High Commissioner for Human Rights  
Standing Committee on European Doctors  
Transplantation Society  
United Nations  
United Nations Economic and Social Council  
United Nations General Assembly  
United Nations General Assembly Special Session on HIV/AIDS  
World Confederation for Physical Therapy  
World Conference on Human Rights  
World Health Assembly  
World Health Organization  
World Medical Association  
World Psychiatric Association

## LIST OF CODES AND DECLARATIONS

12-POINT PROGRAMME FOR THE PREVENTION OF TORTURE  
14-POINT PROGRAMME FOR THE PREVENTION OF “DISAPPEARANCES”  
14-POINT PROGRAMME FOR THE PREVENTION OF EXTRAJUDICIAL EXECUTIONS  
BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS  
BEIJING DECLARATION AND PLATFORM FOR ACTION: FOURTH  
WORLD CONFERENCE ON WOMEN  
BODY OF PRINCIPLES FOR THE PROTECTION OF ALL PERSONS UNDER ANY  
FORM OF DETENTION OR IMPRISONMENT  
CAIRO PROGRAMME OF ACTION  
CONFERENCE ON THE ABOLITION OF THE DEATH PENALTY:  
DECLARATION OF STOCKHOLM  
CONSTITUTION OF THE WORLD HEALTH ORGANIZATION  
CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR  
DEGRADING TREATMENT OR PUNISHMENT  
CONVENTION ON THE ELIMINATION OF ALL FORMS OF  
DISCRIMINATION AGAINST WOMEN  
CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES  
CONVENTION ON THE RIGHTS OF THE CHILD  
DECLARATION AGAINST TORTURE  
DECLARATION OF ALMA-ATA  
DECLARATION OF COMMITMENT ON HIV/AIDS  
DECLARATION OF HAMBURG CONCERNING SUPPORT FOR MEDICAL DOCTORS  
DECLARATION OF HAWAII  
DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR RESEARCH INVOLVING  
HUMAN SUBJECTS  
DECLARATION OF ISTANBUL ON ORGAN TRAFFICKING AND TRANSPLANT TOURISM  
DECLARATION OF MALTA ON HUNGER STRIKERS  
DECLARATION OF TOKYO  
DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN  
DECLARATION ON THE PARTICIPATION OF PSYCHIATRISTS IN THE DEATH PENALTY  
DECLARATION ON THE RIGHTS OF MENTALLY RETARDED PERSONS  
DECLARATION ON THERAPEUTIC ABORTION  
DECLARATION OF PRINCIPLE – TORTURE  
DUAL LOYALTY AND HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE: PROPOSED  
GUIDELINES AND INSTITUTIONAL MECHANISMS  
ETHICAL ASPECTS OF HIV INFECTION AND REPRODUCTION  
FEMALE GENITAL MUTILATION

GENERAL COMMENT NO. 14: THE RIGHT TO THE HIGHEST ATTAINABLE  
STANDARD OF HEALTH

GENERAL COMMENT NO. 4: ADOLESCENT HEALTH AND DEVELOPMENT IN THE  
CONTEXT OF THE CONVENTION ON THE RIGHTS OF THE CHILD

GUIDELINES FOR BIOMEDICAL RESEARCH

GUIDING PRINCIPLES ON HUMAN CELL, TISSUE AND ORGAN TRANSPLANTATION

HUMAN ORGAN AND TISSUE TRANSPLANTATION

INTERNATIONAL CODE OF MEDICAL ETHICS

INTERNATIONAL CONVENTION FOR THE PROTECTION OF ALL PERSONS FROM  
ENFORCED DISAPPEARANCE

INTERNATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH INVOLVING  
HUMAN SUBJECTS

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

LONDON DECLARATION

MADRID DECLARATION ON ETHICAL STANDARDS FOR PSYCHIATRIC PRACTICE

MENTAL HEALTH CARE LAW: TEN BASIC PRINCIPLES

MILLENNIUM DEVELOPMENT GOALS

MONTREAL STATEMENT ON THE HUMAN RIGHT TO ESSENTIAL MEDICINES

OATH OF MAIMONIDES

PLAN OF ACTION AGAINST TORTURE

POLICY STATEMENTS REGARDING THE PREVENTION OF FGM AND THE  
MANAGEMENT OF GIRLS AND WOMEN WITH FGM COMPLICATIONS

POLITICAL DECLARATION ON HIV/AIDS

POSITION STATEMENT ON NURSES AND HUMAN RIGHTS

POSITION STATEMENT ON THE ELIMINATION OF FEMALE GENITAL MUTILATION

POSITION STATEMENT ON THE NURSE'S ROLE IN THE CARE OF DETAINEES AND  
PRISONERS

PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND THE  
IMPROVEMENT OF MENTAL HEALTH CARE

PRINCIPLES OF MEDICAL ETHICS

PRINCIPLES ON THE EFFECTIVE DOCUMENTATION OF TORTURE (ISTANBUL PROTOCOL)

PRINCIPLES ON THE EFFECTIVE PREVENTION AND INVESTIGATION OF EXTRA-LEGAL,  
ARBITRARY AND SUMMARY EXECUTIONS

PROFESSIONAL AND ETHICAL RESPONSIBILITIES CONCERNING SEXUAL AND  
REPRODUCTIVE RIGHTS

REGULATIONS IN TIME OF ARMED CONFLICT

RESOLUTION ON COMBATING HIV/AIDS

RESOLUTION ON FEMALE GENITAL MUTILATION

RESOLUTION ON PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT  
RESOLUTION ON THE RESPONSIBILITY OF PHYSICIANS IN THE  
DOCUMENTATION AND DENUNCIATION OF ACTS OF TORTURE  
OR CRUEL OR INHUMAN OR DEGRADING TREATMENT  
RESOLUTION ON VIOLENCE AGAINST WOMEN  
RESOLUTION ON WOMEN'S RIGHTS RELATED TO REPRODUCTIVE AND SEXUAL HEALTH  
RESOLUTION ON WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS – A SOCIAL  
RESPONSIBILITY FOR OBSTETRICIANS AND GYNAECOLOGISTS  
RULES FOR THE PROTECTION OF JUVENILES DEPRIVED OF THEIR LIBERTY  
SAFEGUARDS GUARANTEEING PROTECTION OF THE RIGHTS OF THOSE  
FACING THE DEATH PENALTY  
STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS  
STATEMENT OF MADRID  
STATEMENT OF THE TRANSPLANTATION SOCIETY ETHICS COMMITTEE  
STATEMENT ON ACCESS TO HEALTH CARE  
STATEMENT ON BODY SEARCHES OF PRISONERS  
STATEMENT ON ETHICAL ISSUES CONCERNING PATIENTS WITH MENTAL ILLNESS  
STATEMENT ON FAMILY PLANNING AND THE RIGHT OF A WOMAN TO CONTRACEPTION  
STATEMENT ON FEMALE GENITAL MUTILATION  
STATEMENT ON HIV/AIDS AND THE MEDICAL PROFESSION  
STATEMENT ON HUMAN TISSUE FOR TRANSPLANTATION  
STATEMENT ON NON-DISCRIMINATION IN PROFESSIONAL MEMBERSHIP AND  
ACTIVITIES OF PHYSICIANS  
STATEMENT ON THE PARTICIPATION OF HEALTH PERSONNEL IN THE DEATH PENALTY  
THE GENEVA CONVENTIONS – COMMON ARTICLE 3  
THE HIPPOCRATIC OATH  
THE NUREMBERG CODE  
THE OATH OF ATHENS  
TORTURE, DEATH PENALTY AND PARTICIPATION BY NURSES IN EXECUTIONS  
UNIVERSAL DECLARATION OF ETHICAL PRINCIPLES FOR PSYCHOLOGISTS  
UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS  
UNIVERSAL DECLARATION ON THE HUMAN GENOME AND HUMAN RIGHTS  
VIENNA DECLARATION AND PROGRAMME OF ACTION  
VIOLENCE AGAINST WOMEN

## GLOSSARY OF ACRONYMS

AD	Alzheimer's Disease
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Committee on the Elimination of Discrimination against Women
CIOMS	Council for International Organizations of Medical Sciences
FGM	Female Genital Mutilation
FIGO	International Federation of Gynecology and Obstetrics
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
ICN	International Council of Nurses
ILO	International Labour Organization
STD	Sexually Transmitted Disease
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UDHR	United Nations Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WMA	World Medical Association
WPA	World Psychiatric Association

# CODES OF ETHICS AND DECLARATIONS RELEVANT TO THE HEALTH PROFESSIONS

## INTRODUCTION

In 1984 Amnesty International published its first compilation of ethical codes and declarations relevant to the medical profession. It has been subject to four revisions since the first version was published. In its own work, Amnesty International had previously touched on important ethical issues. In 1976 the organization published *Codes of Professional Ethics*,<sup>1</sup> which contained codes (or draft codes) of ethics for doctors as well as for nurses, the police, and lawyers. Other documents have also clarified the organization's view that professional ethics could play an important part in protecting human rights.<sup>2</sup> The ever-expanding number of codes, declarations, programs and other documents relevant to the work of health professionals shows the increasing relevance of professional standards in the field of human rights.

Human rights are protected by a variety of mechanisms, including national laws and constitutions and by regional and international treaties. Medical ethics meanwhile are protected by codes devised and monitored primarily by the medical profession. The principles of medical ethics are universal: beneficence (to maximize best health outcomes), non-maleficence (to do no harm), autonomy (to ensure rights of persons to make informed choices about their own health care), and justice; all are consistent with the general principles of human rights.

Codes of ethics need to be applied within a framework of human rights if they are to be feasibly put into practice. Behaving ethically in a society in which human rights are trampled on will not be very meaningful in practice. Therefore those who work towards the ethical practice of medicine, nursing and other health sciences have a stake in the promotion and protection of human rights. Similarly, those who work for the defence of human rights should seek to promote a consciousness of professional ethics, particularly with respect to practice involving the vulnerable members of society: the young, the old, the physically and mentally infirm and those

---

1. The publication was revised in a second edition in 1984, a third edition in 1994 and a fourth edition in 2000.

2. See the discussion of the health professional role in the prevention of torture in *Combating torture: a manual for action*. Index: ACT 40/001/2003.

institutionalized in prisons, secure hospitals, psychiatric institutions and juvenile facilities, and those who have already been victimized whether by the state, by groups or by individuals in wider society.

Codes of professional ethics have the potential to help protect prisoners and detainees from human rights violations by setting out in unambiguous terms the prohibition against medical participation in torture and other abuses. They also serve an important role by giving doctors and other health personnel a clear vision of their role as a guardian of the well-being of their patients. Equally importantly, ethical codes can set out a framework of support for those professionals resisting pressure to assist in the ill-treatment of their charges, and can provide a standard to assess the behaviour of doctors and others alleged to have assisted in torture or mistreatment. This potential function of ethics has not yet been fully realized and further measures are needed to help medical ethics better fulfil their important protective function. Foremost among these measures is the dissemination of the key standards with their central messages, and their incorporation into teaching and professional practice. It is essential that each code or statement is seen as a starting point for continual monitoring, review and regulation, rather than as a mere symbol of consensus on a particular human rights issue (as important as that is).

The statements contained in this volume come from a number of sources:

- Amnesty International itself;
- Professional bodies: physicians, psychiatrists, obstetricians, gynaecologists, nurses, midwives, psychologists, prison physicians;
- The Geneva Conventions (Common Article 3);
- Antiquity (e.g. the Hippocratic Oath, the Oath of Maimonides);
- The United Nations;
- *Ad hoc* international medical bodies.

Amnesty International has compiled and reproduced these statements in this collection for use and reference by health professionals working with respect to human right concerns. Although none of the ethical declarations are enforceable in a court of law, they nevertheless represent an international consensus and therefore carry unquestionable moral authority. They should be used whenever it is appropriate to refer to the medical–ethical dimension of human rights. Some of the United Nations instruments do have the force of law, although the establishment of case law on the issues they cover is slow to develop.

Health professionals have been active in the work of Amnesty International since its inception in 1961, and have played an increasingly valuable role in documenting human rights abuses, arranging treatment for victims of such abuses, and campaigning for the observance, and indeed the strengthening, of human rights and ethical standards. This compilation is intended to contribute to the effectiveness of such work in the future.

The texts are arranged alphabetically by theme.

# 1/ANCIENT OATHS

- The Hippocratic Oath (5th Century BCE)
- Oath of Maimonides (12th Century)

## THE HIPPOCRATIC OATH

*(5th Century BCE)*

*It is not certain that the Hippocratic Oath was written by Hippocrates but it was probably written during his lifetime. The earliest surviving references to this Oath date from the 1st century AD. These suggested that the Oath was seen as an ideal rather than a norm, and it was not until the 4th century that it was an obligatory requirement for the doctor to take the Oath before practising.*

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art – if they desire to learn it – without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Available online at: [http://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html)

## OATH OF MAIMONIDES

*(12th Century)*

*Moshe Maimonides was a 12th Century Jewish philosopher and physician who grew up in Moorish Spain but fled to Cairo because of rising anti-Semitism.*

The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.

May I never see in the patient anything but a fellow creature in pain.

Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.

Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today. Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling.

Available online at: <http://www.fordham.edu/halsall/source/rambam-oath.html>

## 2/ARMED CONFLICT

- The Geneva Conventions – Common Article 3 (Geneva Conventions, 1949)
- Regulations in Time of Armed Conflict (World Medical Association, 1956, last revised 2006)

### THE GENEVA CONVENTIONS – COMMON ARTICLE 3

*(Geneva Conventions, 1949)*

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

**1.** Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- a. violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- b. taking of hostages;
- c. outrages upon personal dignity, in particular humiliating and degrading treatment;
- d. the passing of sentences and the carrying out of executions without previous judgement pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

**2.** The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

The Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.

The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

The four Geneva Conventions and additional Protocols are:

**Convention I** For the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.

**Convention II** For the Amelioration of the Condition of the Wounded and Sick and Shipwrecked Members of Armed Forces at Sea. Geneva, 12 August 1949.

**Convention III** Relative to the Treatment of Prisoners of War. Geneva, 12 August 1949.

**Convention IV** Relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949.

**Protocol I** Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 8 June 1977.

**Protocol II** Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977.

**Protocol III** Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005.

Available online at: <http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/genevaconventions?opendocument>

## REGULATIONS IN TIME OF ARMED CONFLICT

*(World Medical Association, 1956-2006)*

1. Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.
2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:
  - a. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care.
  - b. Weaken the physical or mental strength of a human being without therapeutic justification.
  - c. Employ scientific knowledge to imperil health or destroy life.
  - d. Employ personal health information to facilitate interrogation.
  - e. Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.
3. During times of armed conflict, standard ethical norms apply, not only in regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.
4. The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the required care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion.

5. Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict. This obligation includes a requirement to protect health care personnel.
6. As in peacetime, medical confidentiality must be preserved by the physician. Also as in peacetime, however, there may be circumstances in which a patient poses a significant risk to other people and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.
7. Privileges and facilities afforded to physicians and other health care professionals in times of armed conflict must never be used for other than health care purposes.
8. Physicians have a clear duty to care for the sick and injured. Provision of such care should not be impeded or regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.
9. Physicians have a duty to press governments and other authorities for the provision of the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.
10. Where conflict appears to be imminent and inevitable, physicians should as far as they are able, ensure that authorities are planning for the repair of the public health infrastructure in the immediate post-conflict period.
11. In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.
12. Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.
13. In fulfilling their duties, physicians and other health care professionals shall usually be identified by internationally recognized symbols such as the Red Cross and Red Crescent.
14. Hospitals and health care facilities situated in war regions must be respected by combatants and media personnel. Health care given to the sick and wounded, civilians or combatants cannot be used for morbid publicity or propaganda. The privacy of the sick, wounded and dead must always be respected.

Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, and edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957; amended by the 35th World Medical Assembly, Venice, Italy, October 1983 and the WMA General Assembly, Tokyo 2004; editorially revised at the 173rd Council Session, Divonne-les-Bains, France, May 2006.

## 3/BIO MEDICAL RESEARCH

- The Nuremberg Code (International Military Tribunal, 1947)
- Declaration of Helsinki – Ethical Principles for Research Involving Human Subjects (World Medical Association, 1964, last revised 2008)
- Universal Declaration on the Human Genome and Human Rights (UNESCO, 1997)
- International Ethical Guidelines for Biomedical Research Involving Human Subjects (Council for International Organizations of Medical Sciences, 2002)
- Universal Declaration on Bioethics and Human Rights (UNESCO, 2005)

### THE NUREMBERG CODE

*(International Military Tribunal, 1947)*

The great weight of the evidence before us [judges] is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

**1.** The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

**2.** The experiment should be such as to yield fruitful results for the good of

society, unprocurable by other methods or means of study, and not random or unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and knowledge of the natural history of the disease or other problems under study that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur, except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

*Trials of War Criminals before the Nuremberg Military Tribunals Under Control Council Law, No 10, Vol. II. Nuremberg, Germany, October 1946-April 1949. Washington, DC: US Government Printing Office, 1949, pp 181-182.*

Available online at: <http://www.sahealthinfo.org/ethics/book1appen7.htm>

## DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR RESEARCH INVOLVING HUMAN SUBJECTS

*(World Medical Association, 1964–2008)*

### INTRODUCTION

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.

The Declaration is intended to be read as a whole and each of its constituent paragraphs should not be applied without consideration of all other relevant paragraphs.

2. Although the Declaration is addressed primarily to physicians, the WMA encourages other participants in medical research involving human subjects to adopt these principles.
3. It is the duty of the physician to promote and safeguard the health of patients, including those who are involved in medical research. The physician's knowledge and conscience are dedicated to the fulfilment of this duty.
4. The Declaration of Geneva of the WMA binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act in the patient's best interest when providing medical care."
5. Medical progress is based on research that ultimately must include studies involving human subjects. Populations that are underrepresented in medical research should be provided appropriate access to participation in research.
6. In medical research involving human subjects, the well-being of the individual research subject must take precedence over all other interests.
7. The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best current interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality.
8. In medical practice and in medical research, most interventions involve risks and burdens.
9. Medical research is subject to ethical standards that promote respect for all human subjects and protect their health and rights. Some research populations are particularly vulnerable and need special protection. These include those who cannot give or refuse consent for themselves and those who may be vulnerable to coercion or undue influence.
10. Physicians should consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration.

#### **BASIC PRINCIPLES FOR ALL MEDICAL RESEARCH**

11. It is the duty of physicians who participate in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects.
12. Medical research involving human subjects must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.
13. Appropriate caution must be exercised in the conduct of medical research that may harm the environment.

**14.** The design and performance of each research study involving human subjects must be clearly described in a research protocol. The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, other potential conflicts of interest, incentives for subjects and provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study. The protocol should describe arrangements for post-study access by study subjects to interventions identified as beneficial in the study or access to other appropriate care or benefits.

**15.** The research protocol must be submitted for consideration, comment, guidance and approval to a research ethics committee before the study begins. This committee must be independent of the researcher, the sponsor and any other undue influence. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration. The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the committee, especially information about any serious adverse events. No change to the protocol may be made without consideration and approval by the committee.

**16.** Medical research involving human subjects must be conducted only by individuals with the appropriate scientific training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional. The responsibility for the protection of research subjects must always rest with the physician or other health care professional and never the research subjects, even though they have given consent.

**17.** Medical research involving a disadvantaged or vulnerable population or community is only justified if the research is responsive to the health needs and priorities of this population or community and if there is a reasonable likelihood that this population or community stands to benefit from the results of the research.

**18.** Every medical research study involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and communities involved in the research in comparison with foreseeable benefits to them and to other individuals or communities affected by the condition under investigation.

**19.** Every clinical trial must be registered in a publicly accessible database before recruitment of the first subject.

**20.** Physicians may not participate in a research study involving human subjects unless they are confident that the risks involved have been adequately assessed and can be satisfactorily managed. Physicians must immediately stop a study when the risks are found to outweigh the potential benefits or when there is conclusive proof of positive and beneficial results.

21. Medical research involving human subjects may only be conducted if the importance of the objective outweighs the inherent risks and burdens to the research subjects.
22. Participation by competent individuals as subjects in medical research must be voluntary. Although it may be appropriate to consult family members or community leaders, no competent individual may be enrolled in a research study unless he or she freely agrees.
23. Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information and to minimize the impact of the study on their physical, mental and social integrity.
24. In medical research involving competent human subjects, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information. After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent, preferably in writing. If the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed.
25. For medical research using identifiable human material or data, physicians must normally seek consent for the collection, analysis, storage and/or reuse. There may be situations where consent would be impossible or impractical to obtain for such research or would pose a threat to the validity of the research. In such situations the research may be done only after consideration and approval of a research ethics committee.
26. When seeking informed consent for participation in a research study the physician should be particularly cautious if the potential subject is in a dependent relationship with the physician or may consent under duress. In such situations the informed consent should be sought by an appropriately qualified individual who is completely independent of this relationship.
27. For a potential research subject who is incompetent, the physician must seek informed consent from the legally authorized representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the population represented by the potential subject, the research cannot instead be performed with competent persons, and the research entails only minimal risk and minimal burden.
28. When a potential research subject who is deemed incompetent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorized representative. The potential subject's dissent should be respected.

**29.** Research involving subjects who are physically or mentally incapable of giving consent, for example, unconscious patients, may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research population. In such circumstances the physician should seek informed consent from the legally authorized representative. If no such representative is available and if the research cannot be delayed, the study may proceed without informed consent provided that the specific reasons for involving subjects with a condition that renders them unable to give informed consent have been stated in the research protocol and the study has been approved by a research ethics committee. Consent to remain in the research should be obtained as soon as possible from the subject or a legally authorized representative.

**30.** Authors, editors and publishers all have ethical obligations with regard to the publication of the results of research. Authors have a duty to make publicly available the results of their research on human subjects and are accountable for the completeness and accuracy of their reports. They should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results should be published or otherwise made publicly available. Sources of funding, institutional affiliations and conflicts of interest should be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

#### **ADDITIONAL PRINCIPLES FOR MEDICAL RESEARCH COMBINED WITH MEDICAL CARE**

**31.** The physician may combine medical research with medical care only to the extent that the research is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

**32.** The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best current proven intervention, except in the following circumstances:

- The use of placebo, or no treatment, is acceptable in studies where no current proven intervention exists; or

- Where for compelling and scientifically sound methodological reasons the use of placebo is necessary to determine the efficacy or safety of an intervention and the patients who receive placebo or no treatment will not be subject to any risk of serious or irreversible harm. Extreme care must be taken to avoid abuse of this option.

**33.** At the conclusion of the study, patients entered into the study are entitled to be informed about the outcome of the study and to share any benefits that result from it, for example, access to interventions identified as beneficial in the study or to other appropriate care or benefits.

**34.** The physician must fully inform the patient which aspects of the care are related to the research. The refusal of a patient to participate in a study or the

patient's decision to withdraw from the study must never interfere with the patient-physician relationship.

**35.** In the treatment of a patient, where proven interventions do not exist or have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. Where possible, this intervention should be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information should be recorded and, where appropriate, made publicly available.

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964, and amended by the: 29th WMA General Assembly, Tokyo, Japan, October 1975, 35th WMA General Assembly, Venice, Italy, October 1983, 41st WMA General Assembly, Hong Kong, September 1989, 48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996, 52nd WMA General Assembly, Edinburgh, Scotland, October 2000, 53rd WMA General Assembly, Washington 2002 (Note of Clarification on paragraph 29 added), 55th WMA General Assembly, Tokyo 2004 (Note of Clarification on Paragraph 30 added), 59th WMA General Assembly, Seoul, October 2008.

Available online at: <http://www.wma.net/e/policy/b3.htm>

## UNIVERSAL DECLARATION ON THE HUMAN GENOME AND HUMAN RIGHTS

*(UNESCO, 1997)*

The Universal Declaration on the Human Genome and Human Rights was adopted by the General Conference of UNESCO at its 29th session on 11 November 1997. It is the first universal instrument in the field of biology.

### THE GENERAL CONFERENCE,

**Recalling** that the Preamble of UNESCO's Constitution refers to 'the democratic principles of the dignity, equality and mutual respect of men', rejects any 'doctrine of the inequality of men and races', stipulates 'that the wide diffusion of culture, and the education of humanity for justice and liberty and peace are indispensable to the dignity of men and constitute a sacred duty which all the nations must fulfil in a spirit of mutual assistance and concern', proclaims that 'peace must be founded upon the intellectual and moral solidarity of mankind', and states that the Organization seeks to advance, 'through the educational and scientific and cultural relations of the peoples of the world, the objectives of international peace and of the common welfare of mankind for which the United Nations Organization was established and which its Charter proclaims',

**Solemnly recalling** its attachment to the universal principles of human rights, affirmed in particular in the Universal Declaration of Human Rights of 10 December

1948 and in the two International United Nations Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights of 16 December 1966, in the United Nations Convention on the Prevention and Punishment of the Crime of Genocide of 9 December 1948, the International United Nations Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the United Nations Declaration on the Rights of Mentally Retarded Persons of 20 December 1971, the United Nations Declaration on the Rights of Disabled Persons of 9 December 1975, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women of 18 December 1979, the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power of 29 November 1985, the United Nations Convention on the Rights of the Child of 20 November 1989, the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities of 20 December 1993, the Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction of 16 December 1971, the UNESCO Convention against Discrimination in Education of 14 December 1960, the UNESCO Declaration of the Principles of International Cultural Co-operation of 4 November 1966, the UNESCO Recommendation on the Status of Scientific Researchers of 20 November 1974, the UNESCO Declaration on Race and Racial Prejudice of 27 November 1978, the ILO Convention (No. 111) concerning Discrimination in Respect of Employment and Occupation of 25 June 1958 and the ILO Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries of 27 June 1989,

**Bearing in mind**, and without prejudice to, the international instruments which could have a bearing on the applications of genetics in the field of intellectual property, *inter alia* the Berne Convention for the Protection of Literary and Artistic Works of 9 September 1886 and the UNESCO Universal Copyright Convention of 6 September 1952, as last revised at Paris on 24 July 1971, the Paris Convention for the Protection of Industrial Property of 20 March 1883, as last revised at Stockholm on 14 July 1967, the Budapest Treaty of the WIPO on International Recognition of the Deposit of Micro-organisms for the Purposes of Patent Procedures of 28 April 1977, and the Trade Related Aspects of Intellectual Property Rights Agreement (TRIPs) annexed to the Agreement establishing the World Trade Organization, which entered into force on 1 January 1995,

**Bearing in mind also** the United Nations Convention on Biological Diversity of 5 June 1992 and emphasizing in that connection that the recognition of the genetic diversity of humanity must not give rise to any interpretation of a social or political nature which could call into question 'the inherent dignity and (...) the equal and inalienable rights of all members of the human family', in accordance with the Preamble to the Universal Declaration of Human Rights,

**Recalling** 22 C/Resolution 13.1, 23 C/Resolution 13.1, 24 C/Resolution 13.1, 25 C/Resolutions 5.2 and 7.3, 27 C/Resolution 5.15 and 28 C/Resolutions 0.12, 2.1 and 2.2, urging UNESCO to promote and develop ethical studies, and the actions arising out of them, on the consequences of scientific and technological progress

in the fields of biology and genetics, within the framework of respect for human rights and fundamental freedoms,

**Recognizing** that research on the human genome and the resulting applications open up vast prospects for progress in improving the health of individuals and of humankind as a whole, but **emphasizing** that such research should fully respect human dignity, freedom and human rights, as well as the prohibition of all forms of discrimination based on genetic characteristics,

**Proclaims** the principles that follow and **adopts** the present Declaration.

## **A. HUMAN DIGNITY AND THE HUMAN GENOME**

**Article 1** The human genome underlies the fundamental unity of all members of the human family, as well as the recognition of their inherent dignity and diversity. In a symbolic sense, it is the heritage of humanity.

### **Article 2**

- a. Everyone has a right to respect for their dignity and for their rights regardless of their genetic characteristics.
- b. That dignity makes it imperative not to reduce individuals to their genetic characteristics and to respect their uniqueness and diversity.

**Article 3** The human genome, which by its nature evolves, is subject to mutations. It contains potentialities that are expressed differently according to each individual's natural and social environment, including the individual's state of health, living conditions, nutrition and education.

**Article 4** The human genome in its natural state shall not give rise to financial gains.

## **B. RIGHTS OF THE PERSONS CONCERNED**

### **Article 5**

- a. Research, treatment or diagnosis affecting an individual's genome shall be undertaken only after rigorous and prior assessment of the potential risks and benefits pertaining thereto and in accordance with any other requirement of national law.
- b. In all cases, the prior, free and informed consent of the person concerned shall be obtained. If the latter is not in a position to consent, consent or authorization shall be obtained in the manner prescribed by law, guided by the person's best interest.
- c. The right of each individual to decide whether or not to be informed of the results of genetic examination and the resulting consequences should be respected.
- d. In the case of research, protocols shall, in addition, be submitted for prior review in accordance with relevant national and international research standards or guidelines.
- e. If according to the law a person does not have the capacity to consent, research affecting his or her genome may only be carried out for his or her direct health benefit, subject to the authorization and the protective conditions

prescribed by law. Research which does not have an expected direct health benefit may only be undertaken by way of exception, with the utmost restraint, exposing the person only to a minimal risk and minimal burden and if the research is intended to contribute to the health benefit of other persons in the same age category or with the same genetic condition, subject to the conditions prescribed by law, and provided such research is compatible with the protection of the individual's human rights.

**Article 6** No one shall be subjected to discrimination based on genetic characteristics that is intended to infringe or has the effect of infringing human rights, fundamental freedoms and human dignity.

**Article 7** Genetic data associated with an identifiable person and stored or processed for the purposes of research or any other purpose must be held confidential in the conditions set by law.

**Article 8** Every individual shall have the right, according to international and national law, to just reparation for any damage sustained as a direct and determining result of an intervention affecting his or her genome.

**Article 9** In order to protect human rights and fundamental freedoms, limitations to the principles of consent and confidentiality may only be prescribed by law, for compelling reasons within the bounds of public international law and the international law of human rights.

### C. RESEARCH ON THE HUMAN GENOME

**Article 10** No research or research applications concerning the human genome, in particular in the fields of biology, genetics and medicine, should prevail over respect for the human rights, fundamental freedoms and human dignity of individuals or, where applicable, of groups of people.

**Article 11** Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted. States and competent international organizations are invited to co-operate in identifying such practices and in taking, at national or international level, the measures necessary to ensure that the principles set out in this Declaration are respected.

#### **Article 12**

- a. Benefits from advances in biology, genetics and medicine, concerning the human genome, shall be made available to all, with due regard for the dignity and human rights of each individual.
- b. Freedom of research, which is necessary for the progress of knowledge, is part of freedom of thought. The applications of research, including applications in biology, genetics and medicine, concerning the human genome, shall seek to offer relief from suffering and improve the health of individuals and humankind as a whole.

### D. CONDITIONS FOR THE EXERCISE OF SCIENTIFIC ACTIVITY

**Article 13** The responsibilities inherent in the activities of researchers, including

meticulousness, caution, intellectual honesty and integrity in carrying out their research as well as in the presentation and utilization of their findings, should be the subject of particular attention in the framework of research on the human genome, because of its ethical and social implications. Public and private science policy-makers also have particular responsibilities in this respect.

**Article 14** States should take appropriate measures to foster the intellectual and material conditions favorable to freedom in the conduct of research on the human genome and to consider the ethical, legal, social and economic implications of such research, on the basis of the principles set out in this Declaration.

**Article 15** States should take appropriate steps to provide the framework for the free exercise of Research on the human genome with due regard for the principles set out in this Declaration, in order to safeguard respect for human rights, fundamental freedoms and human dignity and to protect public health. They should seek to ensure that research results are not used for non-peaceful purposes.

**Article 16** States should recognize the value of promoting, at various levels, as appropriate, the establishment of independent, multidisciplinary and pluralist ethics committees to assess the ethical, legal and social issues raised by research on the human genome and its applications.

## **E. SOLIDARITY AND INTERNATIONAL CO-OPERATION**

**Article 17** States should respect and promote the practice of solidarity towards individuals, families and population groups who are particularly vulnerable to or affected by disease or disability of a genetic character. They should foster, *inter alia*, research on the identification, prevention and treatment of genetically based and genetically influenced diseases, in particular rare as well as endemic diseases which affect large numbers of the world's population.

**Article 18** States should make every effort, with due and appropriate regard for the principles set out in this Declaration, to continue fostering the international dissemination of scientific knowledge concerning the human genome, human diversity and genetic research and, in that regard, to foster scientific and cultural co-operation, particularly between industrialized and developing countries.

### **Article 19**

- a. In the framework of international co-operation with developing countries, states should seek to encourage measures enabling:
  - i assessment of the risks and benefits pertaining to research on the human genome to be carried out and abuse to be prevented;
  - ii the capacity of developing countries to carry out research on human biology and genetics, taking into consideration their specific problems, to be developed and strengthened;
  - iii developing countries to benefit from the achievements of scientific and technological research so that their use in favour of economic and social progress can be to the benefit of all;
  - iv the free exchange of scientific knowledge and information in the

areas of biology, genetics and medicine to be promoted.

- b. Relevant international organizations should support and promote the initiatives taken by states for the above-mentioned purposes.

## **F. PROMOTION OF THE PRINCIPLES SET OUT IN THE DECLARATION**

**Article 20** States should take appropriate measures to promote the principles set out in the Declaration, through education and relevant means, *inter alia* through the conduct of research and training in interdisciplinary fields and through the promotion of education in bioethics, at all levels, in particular for those responsible for science policies.

**Article 21** States should take appropriate measures to encourage other forms of research, training and information dissemination conducive to raising the awareness of society and all of its members of their responsibilities regarding the fundamental issues relating to the defense of human dignity which may be raised by research in biology, in genetics and in medicine, and its applications. They should also undertake to facilitate on this subject an open international discussion, ensuring the free expression of various socio-cultural, religious and philosophical opinions.

## **G. IMPLEMENTATION OF THE DECLARATION**

**Article 22** States should make every effort to promote the principles set out in this Declaration and should, by means of all appropriate measures, promote their implementation.

**Article 23** States should take appropriate measures to promote, through education, training and information dissemination, respect for the above-mentioned principles and to foster their recognition and effective application. States should also encourage exchanges and networks among independent ethics committees, as they are established, to foster full collaboration.

**Article 24** The International Bioethics Committee of UNESCO should contribute to the dissemination of the principles set out in this Declaration and to the further examination of issues raised by their applications and by the evolution of the technologies in question. It should organize appropriate consultations with parties concerned, such as vulnerable groups. It should make recommendations, in accordance with UNESCO's statutory procedures, addressed to the General Conference and give advice concerning the follow-up of this Declaration, in particular regarding the identification of practices that could be contrary to human dignity, such as germ-line interventions.

**Article 25** Nothing in this Declaration may be interpreted as implying for any state, group or person any claim to engage in any activity or to perform any act contrary to human rights and fundamental freedoms, including the principles set out in this Declaration.

## INTERNATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS

*(Council for International Organizations of Medical Sciences, 2002)*

### INTRODUCTION

This is the third in the series of international ethical guidelines for biomedical research involving human subjects issued by the Council for International Organizations of Medical Sciences since 1982. Its scope and preparation reflect well the transformation that has occurred in the field of research ethics in the almost quarter century since CIOMS first undertook to make this contribution to medical sciences and the ethics of research. The CIOMS Guidelines, with their stated concern for the application of the Declaration of Helsinki in developing countries, necessarily reflect the conditions and the needs of biomedical research in those countries, and the implications for multinational or transnational research in which they may be partners.

An issue, mainly for those countries and perhaps less pertinent now than in the past, has been the extent to which ethical principles are considered universal or as culturally relative – the universalist versus the pluralist view. The challenge to international research ethics is to apply universal ethical principles to biomedical research in a multicultural world with a multiplicity of health-care systems and considerable variation in standards of health care. The Guidelines take the position that research involving human subjects must not violate any universally applicable ethical standards, but acknowledge that, in superficial aspects, the application of the ethical principles, e.g., in relation to individual autonomy and informed consent, needs to take account of cultural values, while respecting absolutely the ethical standards.

Related to this issue is that of the human rights of research subjects, as well as of health professionals as researchers in a variety of sociocultural contexts, and the contribution that international human rights instruments can make in the application of the general principles of ethics to research involving human subjects. The issue concerns largely, though not exclusively, two principles: respect for autonomy and protection of dependent or vulnerable persons and populations. In the preparation of the Guidelines the potential contribution in these respects of human rights instruments and norms was discussed, and the Guideline drafters have represented the views of commentators on safeguarding the corresponding rights of subjects.

Certain areas of research are not represented by specific guidelines. One such is human genetics. It is, however, considered in Guideline 18 Commentary under Issues of confidentiality in genetics research. The ethics of genetics research was the subject of a commissioned paper and commentary.

Another unrepresented area is research with products of conception (embryo and fetal research, and fetal tissue research). An attempt to craft a guideline on the topic proved unfeasible. At issue was the moral status of embryos and fetuses and the degree to which risks to the life or well-being of these entities are ethically permissible.

In relation to the use of comparators in controls, commentators have raised the question of standard of care to be provided to a control group. They emphasize that standard of care refers to more than the comparator drug or other intervention, and that research subjects in the poorer countries do not usually enjoy the same standard of all-round care enjoyed by subjects in richer countries. This issue is not addressed specifically in the Guidelines.

In one respect the Guidelines depart from the terminology of the Declaration of Helsinki. 'Best current intervention' is the term most commonly used to describe the active comparator that is ethically preferred in controlled clinical trials. For many indications, however, there is more than one established 'current' intervention and expert clinicians do not agree on which is superior. In other circumstances in which there are several established 'current' interventions, some expert clinicians recognize one as superior to the rest; some commonly prescribe another because the superior intervention may be locally unavailable, for example, or prohibitively expensive or unsuited to the capability of particular patients to adhere to a complex and rigorous regimen. 'Established effective intervention' is the term used in Guideline 11 to refer to all such interventions, including the best and the various alternatives to the best. In some cases an ethical review committee may determine that it is ethically acceptable to use an established effective intervention as a comparator, even in cases where such an intervention is not considered the best current intervention.

The mere formulation of ethical guidelines for biomedical research involving human subjects will hardly resolve all the moral doubts that can arise in association with much research, but the Guidelines can at least draw the attention of sponsors, investigators and ethical review committees to the need to consider carefully the ethical implications of research protocols and the conduct of research, and thus conduce to high scientific and ethical standards of biomedical research.

## **INTERNATIONAL INSTRUMENTS AND GUIDELINES**

The first international instrument on the ethics of medical research, the Nuremberg Code, was promulgated in 1947 as a consequence of the trial of physicians (the Doctors' Trial) who had conducted atrocious experiments on unconsenting prisoners and detainees during the second world war. The Code, designed to protect the integrity of the research subject, set out conditions for the ethical conduct of research involving human subjects, emphasizing their voluntary consent to research.

The Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations in 1948. To give the Declaration legal as well as moral force, the General Assembly adopted in 1966 the International Covenant on Civil and Political Rights. Article 7 of the Covenant states "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". It is through this statement that society expresses the fundamental human value that is held to govern all research involving human subjects – the protection of the rights and welfare of all human subjects of scientific experimentation.

The Declaration of Helsinki, issued by the World Medical Association in 1964, is the fundamental document in the field of ethics in biomedical research and has influenced the formulation of international, regional and national legislation and codes of conduct. The Declaration, amended several times, most recently in 2000 (Appendix 2), is a comprehensive international statement of the ethics of research involving human subjects. It sets out ethical guidelines for physicians engaged in both clinical and nonclinical biomedical research.

Since the publication of the CIOMS 1993 Guidelines, several international organizations have issued ethical guidance on clinical trials. This has included, from the World Health Organization, in 1995, Guidelines for Good Clinical Practice for Trials on Pharmaceutical Products; and from the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), in 1996, Guideline on Good Clinical Practice, designed to ensure that data generated from clinical trials are mutually acceptable to regulatory authorities in the European Union, Japan and the United States of America. The Joint United Nations Programme on HIV/AIDS published in 2000 the UNAIDS Guidance Document *Ethical Considerations in HIV Preventive Vaccine Research*.

In 2001 the Council of Ministers of the European Union adopted a Directive on clinical trials, which will be binding in law in the countries of the Union from 2004. The Council of Europe, with more than 40 member States, is developing a Protocol on Biomedical Research, which will be an additional protocol to the Council's 1997 Convention on Human Rights and Biomedicine.

Not specifically concerned with biomedical research involving human subjects but clearly pertinent, as noted above, are international human rights instruments. These are mainly the Universal Declaration of Human Rights, which, particularly in its science provisions, was highly influenced by the Nuremberg Code; the International Covenant on Civil and Political Rights; and the International Covenant on Economic, Social and Cultural Rights. Since the Nuremberg experience, human rights law has expanded to include the protection of women (Convention on the Elimination of All Forms of Discrimination Against Women) and children (Convention on the Rights of the Child). These and other such international instruments endorse in terms of human rights the general ethical principles that underlie the CIOMS International Ethical Guidelines.

## **GENERAL ETHICAL PRINCIPLES**

All research involving human subjects should be conducted in accordance with three basic ethical principles, namely respect for persons, beneficence and justice. It is generally agreed that these principles, which in the abstract have equal moral force, guide the conscientious preparation of proposals for scientific studies. In varying circumstances they may be expressed differently and given different moral weight, and their application may lead to different decisions or courses of action. The present guidelines are directed at the application of these principles to research involving human subjects.

**Respect for persons** incorporates at least two fundamental ethical considerations, namely:

- a. respect for autonomy, which requires that those who are capable of deliberation about their personal choices should be treated with respect for their capacity for self-determination; and
- b. protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

Beneficence refers to the ethical obligation to maximize benefits and to minimize harms. This principle gives rise to norms requiring that the risks of research be reasonable in the light of the expected benefits, that the research design be sound, and that the investigators be competent both to conduct the research and to safeguard the welfare of the research subjects. Beneficence further proscribes the deliberate infliction of harm on persons; this aspect of beneficence is sometimes expressed as a separate principle, *nonmaleficence* (do no harm).

Justice refers to the ethical obligation to treat each person in accordance with what is morally right and proper, to give each person what is due to him or her. In the ethics of research involving human subjects the principle refers primarily to *distributive justice*, which requires the equitable distribution of both the burdens and the benefits of participation in research. Differences in distribution of burdens and benefits are justifiable only if they are based on morally relevant distinctions between persons; one such distinction is vulnerability. “Vulnerability” refers to a substantial incapacity to protect one’s own interests owing to such impediments as lack of capability to give informed consent, lack of alternative means of obtaining medical care or other expensive necessities, or being a junior or subordinate member of a hierarchical group. Accordingly, special provision must be made for the protection of the rights and welfare of vulnerable persons.

Sponsors of research or investigators cannot, in general, be held accountable for unjust conditions where the research is conducted, but they must refrain from practices that are likely to worsen unjust conditions or contribute to new inequities. Neither should they take advantage of the relative inability of low-resource countries or vulnerable populations to protect their own interests, by conducting research inexpensively and avoiding complex regulatory systems of industrialized countries in order to develop products for the lucrative markets of those countries.

In general, the research project should leave low-resource countries or communities better off than previously or, at least, no worse off. It should be responsive to their health needs and priorities in that any product developed is made reasonably available to them, and as far as possible leave the population in a better position to obtain effective health care and protect its own health.

Justice requires also that the research be responsive to the health conditions or needs of vulnerable subjects. The subjects selected should be the least vulnerable necessary to accomplish the purposes of the research. Risk to vulnerable subjects is most easily justified when it arises from interventions or procedures that

hold out for them the prospect of direct health-related benefit. Risk that does not hold out such prospect must be justified by the anticipated benefit to the population of which the individual research subject is representative.

## PREAMBLE

The term “research” refers to a class of activity designed to develop or contribute to generalizable knowledge. Generalizable knowledge consists of theories, principles or relationships, or the accumulation of information on which they are based, that can be corroborated by accepted scientific methods of observation and inference. In the present context “research” includes both medical and behavioural studies pertaining to human health. Usually “research” is modified by the adjective “biomedical” to indicate its relation to health.

Progress in medical care and disease prevention depends upon an understanding of physiological and pathological processes or epidemiological findings, and requires at some time research involving human subjects. The collection, analysis and interpretation of information obtained from research involving human beings contribute significantly to the improvement of human health.

Research involving human subjects includes:

- studies of a physiological, biochemical or pathological process, or of the response to a specific intervention – whether physical, chemical or psychological – in healthy subjects or patients;
- controlled trials of diagnostic, preventive or therapeutic measures in larger groups of persons, designed to demonstrate a specific generalizable response to these measures against a background of individual biological variation;
- studies designed to determine the consequences for individuals and communities of specific preventive or therapeutic measures; and
- studies concerning human health-related behaviour in a variety of circumstances and environments.

Research involving human subjects may employ either observation or physical, chemical or psychological intervention; it may also either generate records or make use of existing records containing biomedical or other information about individuals who may or may not be identifiable from the records or information. The use of such records and the protection of the confidentiality of data obtained from those records are discussed in *International Guidelines for Ethical Review of Epidemiological Studies* (CIOMS, 1991).

The research may be concerned with the social environment, manipulating environmental factors in a way that could affect incidentally-exposed individuals. It is defined in broad terms in order to embrace field studies of pathogenic organisms and toxic chemicals under investigation for health-related purposes.

Biomedical research with human subjects is to be distinguished from the practice of medicine, public health and other forms of health care, which is designed to contribute directly to the health of individuals or communities.

Prospective subjects may find it confusing when research and practice are to be conducted simultaneously, as when research is designed to obtain new information about the efficacy of a drug or other therapeutic, diagnostic or preventive modality.

As stated in Paragraph 32 of the Declaration of Helsinki, “In the treatment of a patient, where proven prophylactic, diagnostic and therapeutic methods do not exist or have been ineffective, the physician, with informed consent from the patient, must be free to use unproven or new prophylactic, diagnostic and therapeutic measures, if in the physician’s judgement it offers hope of saving life, re-establishing health or alleviating suffering. Where possible, these measures should be made the object of research, designed to evaluate their safety and efficacy. In all cases, new information should be recorded and, where appropriate, published. The other relevant guidelines of this Declaration should be followed.”

Professionals whose roles combine investigation and treatment have a special obligation to protect the rights and welfare of the patient-subjects. An investigator who agrees to act as physician-investigator undertakes some or all of the legal and ethical responsibilities of the subject’s primary-care physician. In such a case, if the subject withdraws from the research owing to complications related to the research or in the exercise of the right to withdraw without loss of benefit, the physician has an obligation to continue to provide medical care, or to see that the subject receives the necessary care in the health-care system, or to offer assistance in finding another physician.

Research with human subjects should be carried out only by, or strictly supervised by, suitably qualified and experienced investigators and in accordance with a protocol that clearly states: the aim of the research; the reasons for proposing that it involve human subjects; the nature and degree of any known risks to the subjects; the sources from which it is proposed to recruit subjects; and the means proposed for ensuring that subjects’ consent will be adequately informed and voluntary. The protocol should be scientifically and ethically appraised by one or more suitably constituted review bodies, independent of the investigators.

New vaccines and medicinal drugs, before being approved for general use, must be tested on human subjects in clinical trials; such trials constitute a substantial part of all research involving human subjects.

## THE GUIDELINES

### **Guideline 1: Ethical justification and scientific validity of biomedical research involving human beings**

The ethical justification of biomedical research involving human subjects is the prospect of discovering new ways of benefiting people’s health. Such research can be ethically justifiable only if it is carried out in ways that respect and protect, and are fair to, the subjects of that research and are morally acceptable within the communities in which the research is carried out. Moreover, because scientifically invalid research is unethical in that it exposes research subjects to risks without

possible benefit, investigators and sponsors must ensure that proposed studies involving human subjects conform to generally accepted scientific principles and are based on adequate knowledge of the pertinent scientific literature.

#### *Commentary on Guideline 1*

Among the essential features of ethically justified research involving human subjects, including research with identifiable human tissue or data, are that the research offers a means of developing information not otherwise obtainable, that the design of the research is scientifically sound, and that the investigators and other research personnel are competent. The methods to be used should be appropriate to the objectives of the research and the field of study. Investigators and sponsors must also ensure that all who participate in the conduct of the research are qualified by virtue of their education and experience to perform competently in their roles. These considerations should be adequately reflected in the research protocol submitted for review and clearance to scientific and ethical review committees (Appendix I).

Scientific review is discussed further in the Commentaries to Guidelines 2 and 3: *Ethical review committees and Ethical review of externally sponsored research*. Other ethical aspects of research are discussed in the remaining guidelines and their commentaries. The protocol designed for submission for review and clearance to scientific and ethical review committees should include, when relevant, the items specified in Appendix I, and should be carefully followed in conducting the research.

#### **Guideline 2: Ethical review committees**

All proposals to conduct research involving human subjects must be submitted for review of their scientific merit and ethical acceptability to one or more scientific review and ethical review committees. The review committees must be independent of the research team, and any direct financial or other material benefit they may derive from the research should not be contingent on the outcome of their review. The investigator must obtain their approval or clearance before undertaking the research. The ethical review committee should conduct further reviews as necessary in the course of the research, including monitoring of the progress of the study.

#### *Commentary on Guideline 2*

Ethical review committees may function at the institutional, local, regional, or national level, and in some cases at the international level. The regulatory or other governmental authorities concerned should promote uniform standards across committees within a country, and, under all systems, sponsors of research and institutions in which the investigators are employed should allocate sufficient resources to the review process. Ethical review committees may receive money for the activity of reviewing protocols, but under no circumstances may payment be offered or accepted for a review committee's approval or clearance of a protocol.

**Scientific review.** According to the Declaration of Helsinki (Paragraph 11), medical research involving humans must conform to generally accepted scientific principles, and be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, where indicated, animal experimentation. Scientific review must consider, *inter alia*, the study design, including the provisions for avoiding or minimizing risk and for monitoring safety. Committees competent to review and approve scientific aspects of research proposals must be multidisciplinary.

**Ethical review.** The ethical review committee is responsible for safeguarding the rights, safety, and well-being of the research subjects. Scientific review and ethical review cannot be separated: scientifically unsound research involving humans as subjects is *ipso facto* unethical in that it may expose them to risk or inconvenience to no purpose; even if there is no risk of injury, wasting of subjects' and researchers' time in unproductive activities represents loss of a valuable resource. Normally, therefore, an ethical review committee considers both the scientific and the ethical aspects of proposed research. It must either carry out a proper scientific review or verify that a competent expert body has determined that the research is scientifically sound. Also, it considers provisions for monitoring of data and safety.

If the ethical review committee finds a research proposal scientifically sound, or verifies that a competent expert body has found it so, it should then consider whether any known or possible risks to the subjects are justified by the expected benefits, direct or indirect, and whether the proposed research methods will minimize harm and maximize benefit. (See Guideline 8: *Benefits and risks of study participation*.) If the proposal is sound and the balance of risks to anticipated benefits is reasonable, the committee should then determine whether the procedures proposed for obtaining informed consent are satisfactory and those proposed for the selection of subjects are equitable.

**Ethical review of emergency compassionate use of an investigational therapy.** In some countries, drug regulatory authorities require that the so-called compassionate or humanitarian use of an investigational treatment be reviewed by an ethical review committee as though it were research. Exceptionally, a physician may undertake the compassionate use of an investigational therapy before obtaining the approval or clearance of an ethical review committee, provided three criteria are met: a patient needs emergency treatment, there is some evidence of possible effectiveness of the investigational treatment, and there is no other treatment available that is known to be equally effective or superior. Informed consent should be obtained according to the legal requirements and cultural standards of the community in which the intervention is carried out. Within one week the physician must report to the ethical review committee the details of the case and the action taken, and an independent health-care professional must confirm in writing to the ethical review committee the treating physician's judgment that the use of the investigational intervention was justified according to the three specified criteria. (See also Guideline 13 Commentary section: *Other vulnerable groups*.)

**National (centralized) or local review.** Ethical review committees may be created under the aegis of national or local health administrations, national (or centralized) medical research councils or other nationally representative bodies. In a highly centralized administration a national, or centralized, review committee may be constituted for both the scientific and the ethical review of research protocols. In countries where medical research is not centrally administered, ethical review is more effectively and conveniently undertaken at a local or regional level. The authority of a local ethical review committee may be confined to a single institution or may extend to all institutions in which biomedical research is carried out within a defined geographical area. The basic responsibilities of ethical review committees are:

- to determine that all proposed interventions, particularly the administration of drugs and vaccines or the use of medical devices or procedures under development, are acceptably safe to be undertaken in humans or to verify that another competent expert body has done so;
- to determine that the proposed research is scientifically sound or to verify that another competent expert body has done so;
- to ensure that all other ethical concerns arising from a protocol are satisfactorily resolved both in principle and in practice;
- to consider the qualifications of the investigators, including education in the principles of research practice, and the conditions of the research site with a view to ensuring the safe conduct of the trial; and
- to keep records of decisions and to take measures to follow up on the conduct of ongoing research projects.

**Committee membership.** National or local ethical review committees should be so composed as to be able to provide complete and adequate review of the research proposals submitted to them. It is generally presumed that their membership should include physicians, scientists and other professionals such as nurses, lawyers, ethicists and clergy, as well as lay persons qualified to represent the cultural and moral values of the community and to ensure that the rights of the research subjects will be respected. They should include both men and women. When uneducated or illiterate persons form the focus of a study they should also be considered for membership or invited to be represented and have their views expressed.

A number of members should be replaced periodically with the aim of blending the advantages of experience with those of fresh perspectives.

A national or local ethical review committee responsible for reviewing and approving proposals for externally sponsored research should have among its members or consultants persons who are thoroughly familiar with the customs and traditions of the population or community concerned and sensitive to issues of human dignity.

Committees that often review research proposals directed at specific diseases or impairments, such as HIV/AIDS or paraplegia, should invite or hear the views of individuals or bodies representing patients with such diseases or impairments.

Similarly, for research involving such subjects as children, students, elderly persons or employees, committees should invite or hear the views of their representatives or advocates.

To maintain the review committee's independence from the investigators and sponsors and to avoid conflict of interest, any member with a special or particular, direct or indirect, interest in a proposal should not take part in its assessment if that interest could subvert the member's objective judgment. Members of ethical review committees should be held to the same standard of disclosure as scientific and medical research staff with regard to financial or other interests that could be construed as conflicts of interest. A practical way of avoiding such conflict of interest is for the committee to insist on a declaration of possible conflict of interest by any of its members. A member who makes such a declaration should then withdraw, if to do so is clearly the appropriate action to take, either at the member's own discretion or at the request of the other members. Before withdrawing, the member should be permitted to offer comments on the protocol or to respond to questions of other members.

**Multi-centre research.** Some research projects are designed to be conducted in a number of centres in different communities or countries. Generally, to ensure that the results will be valid, the study must be conducted in an identical way at each centre. Such studies include clinical trials, research designed for the evaluation of health service programmes, and various kinds of epidemiological research. For such studies, local ethical or scientific review committees are not normally authorized to change doses of drugs, to change inclusion or exclusion criteria, or to make other similar modifications. They should be fully empowered to prevent a study that they believe to be unethical. Moreover, changes that local review committees believe are necessary to protect the research subjects should be documented and reported to the research institution or sponsor responsible for the whole research programme for consideration and due action, to ensure that all other subjects can be protected and that the research will be valid across sites.

To ensure the validity of multi-centre research, any change in the protocol should be made at every collaborating centre or institution, or, failing this, explicit inter-centre comparability procedures must be introduced; changes made at some but not all will defeat the purpose of multi-centre research. For some multi-centre studies, scientific and ethical review may be facilitated by agreement among centres to accept the conclusions of a single review committee; its members could include a representative of the ethical review committee at each of the centres at which the research is to be conducted, as well as individuals competent to conduct scientific review. In other circumstances, a centralized review may be complemented by local review relating to the local participating investigators and institutions. The central committee could review the study from a scientific and ethical standpoint, and the local committees could verify the practicability of the study in their communities, including the infrastructures, the state of training, and ethical considerations of local significance.

In a large multi-centre trial, individual investigators will not have authority to act independently, with regard to data analysis or to preparation and publication of manuscripts, for instance. Such a trial usually has a set of committees which operate under the direction of a steering committee and are responsible for such functions and decisions. The function of the ethical review committee in such cases is to review the relevant plans with the aim of avoiding abuses.

**Sanctions.** Ethical review committees generally have no authority to impose sanctions on researchers who violate ethical standards in the conduct of research involving humans. They may, however, withdraw ethical approval of a research project if judged necessary. They should be required to monitor the implementation of an approved protocol and its progression, and to report to institutional or governmental authorities any serious or continuing non-compliance with ethical standards as they are reflected in protocols that they have approved or in the conduct of the studies. Failure to submit a protocol to the committee should be considered a clear and serious violation of ethical standards.

Sanctions imposed by governmental, institutional, professional or other authorities possessing disciplinary power should be employed as a last resort. Preferred methods of control include cultivation of an atmosphere of mutual trust, and education and support to promote in researchers and in sponsors the capacity for ethical conduct of research.

Should sanctions become necessary, they should be directed at the non-compliant researchers or sponsors. They may include fines or suspension of eligibility to receive research funding, to use investigational interventions, or to practise medicine. Unless there are persuasive reasons to do otherwise, editors should refuse to publish the results of research conducted unethically, and retract any articles that are subsequently found to contain falsified or fabricated data or to have been based on unethical research. Drug regulatory authorities should consider refusal to accept unethically obtained data submitted in support of an application for authorization to market a product. Such sanctions, however, may deprive of benefit not only the errant researcher or sponsor but also that segment of society intended to benefit from the research; such possible consequences merit careful consideration.

**Potential conflicts of interest related to project support.** Increasingly, biomedical studies receive funding from commercial firms. Such sponsors have good reasons to support research methods that are ethically and scientifically acceptable, but cases have arisen in which the conditions of funding could have introduced bias. It may happen that investigators have little or no input into trial design, limited access to the raw data, or limited participation in data interpretation, or that the results of a clinical trial may not be published if they are unfavourable to the sponsor's product. This risk of bias may also be associated with other sources of support, such as government or foundations. As the persons directly responsible for their work, investigators should not enter into agreements that interfere unduly with their access to the data or their ability to analyse the data independently, to prepare manuscripts, or to publish them. Investigators must also disclose potential or

apparent conflicts of interest on their part to the ethical review committee or to other institutional committees designed to evaluate and manage such conflicts. Ethical review committees should therefore ensure that these conditions are met. See also Multi-centre research, above.

### **Guideline 3: Ethical review of externally sponsored research**

An external sponsoring organization and individual investigators should submit the research protocol for ethical and scientific review in the country of the sponsoring organization, and the ethical standards applied should be no less stringent than they would be for research carried out in that country. The health authorities of the host country, as well as a national or local ethical review committee, should ensure that the proposed research is responsive to the health needs and priorities of the host country and meets the requisite ethical standards.

#### *Commentary on Guideline 3*

**Definition.** The term externally sponsored research refers to research undertaken in a host country but sponsored, financed, and sometimes wholly or partly carried out by an external international or national organization or pharmaceutical company with the collaboration or agreement of the appropriate authorities, institutions and personnel of the host country.

**Ethical and scientific review.** Committees in both the country of the sponsor and the host country have responsibility for conducting both scientific and ethical review, as well as the authority to withhold approval of research proposals that fail to meet their scientific or ethical standards. As far as possible, there must be assurance that the review is independent and that there is no conflict of interest that might affect the judgement of members of the review committees in relation to any aspect of the research. When the external sponsor is an international organization, its review of the research protocol must be in accordance with its own independent ethical-review procedures and standards.

Committees in the external sponsoring country or international organization have a special responsibility to determine whether the scientific methods are sound and suitable to the aims of the research; whether the drugs, vaccines, devices or procedures to be studied meet adequate standards of safety; whether there is sound justification for conducting the research in the host country rather than in the country of the external sponsor or in another country; and whether the proposed research is in compliance with the ethical standards of the external sponsoring country or international organization.

Committees in the host country have a special responsibility to determine whether the objectives of the research are responsive to the health needs and priorities of that country. The ability to judge the ethical acceptability of various aspects of a research proposal requires a thorough understanding of a community's customs and traditions. The ethical review committee in the host country, therefore, must have as either members or consultants persons with such understanding; it

will then be in a favourable position to determine the acceptability of the proposed means of obtaining informed consent and otherwise respecting the rights of prospective subjects as well as of the means proposed to protect the welfare of the research subjects. Such persons should be able, for example, to indicate suitable members of the community to serve as intermediaries between investigators and subjects, and to advise on whether material benefits or inducements may be regarded as appropriate in the light of a community's gift-exchange and other customs and traditions.

When a sponsor or investigator in one country proposes to carry out research in another, the ethical review committees in the two countries may, by agreement, undertake to review different aspects of the research protocol. In short, in respect of host countries either with developed capacity for independent ethical review or in which external sponsors and investigators are contributing substantially to such capacity, ethical review in the external, sponsoring country may be limited to ensuring compliance with broadly stated ethical standards. The ethical review committee in the host country can be expected to have greater competence for reviewing the detailed plans for compliance, in view of its better understanding of the cultural and moral values of the population in which it is proposed to conduct the research; it is also likely to be in a better position to monitor compliance in the course of a study. However, in respect of research in host countries with inadequate capacity for independent ethical review, full review by the ethical review committee in the external sponsoring country or international agency is necessary.

#### **Guideline 4: Individual informed consent**

For all biomedical research involving humans the investigator must obtain the voluntary informed consent of the prospective subject or, in the case of an individual who is not capable of giving informed consent, the permission of a legally authorized representative in accordance with applicable law. Waiver of informed consent is to be regarded as uncommon and exceptional, and must in all cases be approved by an ethical review committee.

##### *Commentary on Guideline 4*

**General considerations.** Informed consent is a decision to participate in research, taken by a competent individual who has received the necessary information; who has adequately understood the information; and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement, or intimidation.

Informed consent is based on the principle that competent individuals are entitled to choose freely whether to participate in research. Informed consent protects the individual's freedom of choice and respects the individual's autonomy. As an additional safeguard, it must always be complemented by independent ethical review of research proposals. This safeguard of independent review is particularly important as many individuals are limited in their capacity to give adequate informed

consent; they include young children, adults with severe mental or behavioural disorders, and persons who are unfamiliar with medical concepts and technology (See Guidelines 13, 14, 15).

**Process.** Obtaining informed consent is a process that is begun when initial contact is made with a prospective subject and continues throughout the course of the study. By informing the prospective subjects, by repetition and explanation, by answering their questions as they arise, and by ensuring that each individual understands each procedure, investigators elicit their informed consent and in so doing manifest respect for their dignity and autonomy. Each individual must be given as much time as is needed to reach a decision, including time for consultation with family members or others. Adequate time and resources should be set aside for informed-consent procedures.

**Language.** Informing the individual subject must not be simply a ritual recitation of the contents of a written document. Rather, the investigator must convey the information, whether orally or in writing, in language that suits the individual's level of understanding. The investigator must bear in mind that the prospective subject's ability to understand the information necessary to give informed consent depends on that individual's maturity, intelligence, education and belief system. It depends also on the investigator's ability and willingness to communicate with patience and sensitivity.

**Comprehension.** The investigator must then ensure that the prospective subject has adequately understood the information. The investigator should give each one full opportunity to ask questions and should answer them honestly, promptly and completely. In some instances the investigator may administer an oral or a written test or otherwise determine whether the information has been adequately understood.

**Documentation of consent.** Consent may be indicated in a number of ways. The subject may imply consent by voluntary actions, express consent orally, or sign a consent form. As a general rule, the subject should sign a consent form, or, in the case of incompetence, a legal guardian or other duly authorized representative should do so. The ethical review committee may approve waiver of the requirement of a signed consent form if the research carries no more than minimal risk – that is, risk that is no more likely and not greater than that attached to routine medical or psychological examination – and if the procedures to be used are only those for which signed consent forms are not customarily required outside the research context. Such waivers may also be approved when existence of a signed consent form would be an unjustified threat to the subject's confidentiality. In some cases, particularly when the information is complicated, it is advisable to give subjects information sheets to retain; these may resemble consent forms in all respects except that subjects are not required to sign them. Their wording should be cleared by the ethical review committee. When consent has been obtained orally, investigators are responsible for providing documentation or proof of consent.

**Waiver of the consent requirement.** Investigators should never initiate research involving human subjects without obtaining each subject's informed consent, unless

they have received explicit approval to do so from an ethical review committee. However, when the research design involves no more than minimal risk and a requirement of individual informed consent would make the conduct of the research impracticable (for example, where the research involves only excerpting data from subjects' records), the ethical review committee may waive some or all of the elements of informed consent.

**Renewing consent.** When material changes occur in the conditions or the procedures of a study, and also periodically in long-term studies, the investigator should once again seek informed consent from the subjects. For example, new information may have come to light, either from the study or from other sources, about the risks or benefits of products being tested or about alternatives to them. Subjects should be given such information promptly. In many clinical trials, results are not disclosed to subjects and investigators until the study is concluded. This is ethically acceptable if an ethical review committee has approved their non-disclosure.

**Cultural considerations.** In some cultures an investigator may enter a community to conduct research or approach prospective subjects for their individual consent only after obtaining permission from a community leader, a council of elders, or another designated authority. Such customs must be respected. In no case, however, may the permission of a community leader or other authority substitute for individual informed consent. In some populations the use of a number of local languages may complicate the communication of information to potential subjects and the ability of an investigator to ensure that they truly understand it. Many people in all cultures are unfamiliar with, or do not readily understand, scientific concepts such as those of placebo or randomization. Sponsors and investigators should develop culturally appropriate ways to communicate information that is necessary for adherence to the standard required in the informed consent process. Also, they should describe and justify in the research protocol the procedure they plan to use in communicating information to subjects. For collaborative research in developing countries the research project should, if necessary, include the provision of resources to ensure that informed consent can indeed be obtained legitimately within different linguistic and cultural settings.

**Consent to use for research purposes biological materials (including genetic material) from subjects in clinical trials.** Consent forms for the research protocol should include a separate section for clinical-trial subjects who are requested to provide their consent for the use of their biological specimens for research. Separate consent may be appropriate in some cases (e.g., if investigators are requesting permission to conduct basic research which is not a necessary part of the clinical trial), but not in others (e.g., the clinical trial requires the use of subjects' biological materials).

**Use of medical records and biological specimens.** Medical records and biological specimens taken in the course of clinical care may be used for research without the consent of the patients/subjects only if an ethical review committee has determined that the research poses minimal risk, that the rights or interests of the patients will

not be violated, that their privacy and confidentiality or anonymity are assured, and that the research is designed to answer an important question and would be impracticable if the requirement for informed consent were to be imposed. Patients have a right to know that their records or specimens may be used for research. Refusal or reluctance of individuals to agree to participate would not be evidence of impracticability sufficient to warrant waiving informed consent. Records and specimens of individuals who have specifically rejected such uses in the past may be used only in the case of public health emergencies. (See Guideline 18 Commentary, *Confidentiality between physician and patient*).

**Secondary use of research records or biological specimens.** Investigators may want to use records or biological specimens that another investigator has used or collected for use, in another institution in the same or another country. This raises the issue of whether the records or specimens contain personal identifiers, or can be linked to such identifiers, and by whom. (See also Guideline 18: *Safeguarding confidentiality*) If informed consent or permission was required to authorize the original collection or use of such records or specimens for research purposes, secondary uses are generally constrained by the conditions specified in the original consent. Consequently, it is essential that the original consent process anticipate, to the extent that this is feasible, any foreseeable plans for future use of the records or specimens for research. Thus, in the original process of seeking informed consent a member of the research team should discuss with, and, when indicated, request the permission of, prospective subjects as to:

- i. whether there will or could be any secondary use and, if so, whether such secondary use will be limited with regard to the type of study that may be performed on such materials;
- ii. the conditions under which investigators will be required to contact the research subjects for additional authorization for secondary use;
- iii. the investigators' plans, if any, to destroy or to strip of personal identifiers the records or specimens; and
- iv. the rights of subjects to request destruction or anonymization of biological specimens or of records or parts of records that they might consider particularly sensitive, such as photographs, videotapes or audiotapes.

(See also Guidelines 5: *Obtaining informed consent: Essential information for prospective research subjects*; 6: *Obtaining informed consent: Obligations of sponsors and investigators*; and 7: *Inducement to participate*.)

#### **Guideline 5: Obtaining informed consent: Essential information for prospective research subjects**

Before requesting an individual's consent to participate in research, the investigator must provide the following information, in language or another form of communication that the individual can understand:

1. that the individual is invited to participate in research, the reasons for considering the individual suitable for the research, and that participation is voluntary;

2. that the individual is free to refuse to participate and will be free to withdraw from the research at any time without penalty or loss of benefits to which he or she would otherwise be entitled;
3. the purpose of the research, the procedures to be carried out by the investigator and the subject, and an explanation of how the research differs from routine medical care;
4. for controlled trials, an explanation of features of the research design (e.g., randomization, double-blinding), and that the subject will not be told of the assigned treatment until the study has been completed and the blind has been broken;
5. the expected duration of the individual's participation (including number and duration of visits to the research centre and the total time involved) and the possibility of early termination of the trial or of the individual's participation in it;
6. whether money or other forms of material goods will be provided in return for the individual's participation and, if so, the kind and amount;
7. that, after the completion of the study, subjects will be informed of the findings of the research in general, and individual subjects will be informed of any finding that relates to their particular health status;
8. that subjects have the right of access to their data on demand, even if these data lack immediate clinical utility (unless the ethical review committee has approved temporary or permanent non-disclosure of data, in which case the subject should be informed of, and given, the reasons for such non-disclosure);
9. any foreseeable risks, pain or discomfort, or inconvenience to the individual (or others) associated with participation in the research, including risks to the health or well-being of a subject's spouse or partner;
10. the direct benefits, if any, expected to result to subjects from participating in the research;
11. the expected benefits of the research to the community or to society at large, or contributions to scientific knowledge;
12. whether, when and how any products or interventions proven by the research to be safe and effective will be made available to subjects after they have completed their participation in the research, and whether they will be expected to pay for them;
13. any currently available alternative interventions or courses of treatment;
14. the provisions that will be made to ensure respect for the privacy of subjects and for the confidentiality of records in which subjects are identified;
15. the limits, legal or other, to the investigators' ability to safeguard confidentiality, and the possible consequences of breaches of confidentiality;
16. policy with regard to the use of results of genetic tests and familial genetic information, and the precautions in place to prevent disclosure of the results of a subject's genetic tests to immediate family relatives or to others (e.g., insurance companies or employers) without the consent of the subject;
17. the sponsors of the research, the institutional affiliation of the investigators, and the nature and sources of funding for the research;

18. the possible research uses, direct or secondary, of the subject's medical records and of biological specimens taken in the course of clinical care (See also Guidelines 4 and 18 Commentaries);
19. whether it is planned that biological specimens collected in the research will be destroyed at its conclusion, and, if not, details about their storage (where, how, for how long, and final disposition) and possible future use, and that subjects have the right to decide about such future use, to refuse storage, and to have the material destroyed (See Guideline 4 Commentary);
20. whether commercial products may be developed from biological specimens, and whether the participant will receive monetary or other benefits from the development of such products;
21. whether the investigator is serving only as an investigator or as both investigator and the subject's physician;
22. the extent of the investigator's responsibility to provide medical services to the participant;
23. that treatment will be provided free of charge for specified types of research-related injury or for complications associated with the research, the nature and duration of such care, the name of the organization or individual that will provide the treatment, and whether there is any uncertainty regarding funding of such treatment;
24. in what way, and by what organization, the subject or the subject's family or dependants will be compensated for disability or death resulting from such injury (or, when indicated, that there are no plans to provide such compensation);
25. whether or not, in the country in which the prospective subject is invited to participate in research, the right to compensation is legally guaranteed;
26. that an ethical review committee has approved or cleared the research protocol.

#### **Guideline 6: Obtaining informed consent: Obligations of sponsors and investigators**

Sponsors and investigators have a duty to:

- refrain from unjustified deception, undue influence, or intimidation;
- seek consent only after ascertaining that the prospective subject has adequate understanding of the relevant facts and of the consequences of participation and has had sufficient opportunity to consider whether to participate;
- as a general rule, obtain from each prospective subject a signed form as evidence of informed consent – investigators should justify any exceptions to this general rule and obtain the approval of the ethical review committee (See Guideline 4 Commentary, *Documentation of consent*);
- renew the informed consent of each subject if there are significant changes in the conditions or procedures of the research or if new information becomes available that could affect the willingness of subjects to continue to participate; and,
- renew the informed consent of each subject in long-term studies at pre-determined intervals, even if there are no changes in the design or objectives of the research.

*Commentary on Guideline 6*

**The investigator is responsible for ensuring the adequacy of informed consent from each subject.** The person obtaining informed consent should be knowledgeable about the research and capable of answering questions from prospective subjects. Investigators in charge of the study must make themselves available to answer questions at the request of subjects. Any restrictions on the subject's opportunity to ask questions and receive answers before or during the research undermines the validity of the informed consent.

In some types of research, potential subjects should receive counselling about risks of acquiring a disease unless they take precautions. This is especially true of HIV/AIDS vaccine research (UNAIDS Guidance Document, *Ethical Considerations in HIV Preventive Vaccine Research, Guidance Point 14*).

**Withholding information and deception.** Sometimes, to ensure the validity of research, investigators withhold certain information in the consent process. In biomedical research, this typically takes the form of withholding information about the purpose of specific procedures. For example, subjects in clinical trials are often not told the purpose of tests performed to monitor their compliance with the protocol, since if they knew their compliance was being monitored they might modify their behaviour and hence invalidate results. In most such cases, the prospective subjects are asked to consent to remain uninformed of the purpose of some procedures until the research is completed; after the conclusion of the study they are given the omitted information. In other cases, because a request for permission to withhold some information would jeopardize the validity of the research, subjects are not told that some information has been withheld until the research has been completed. Any such procedure must receive the explicit approval of the ethical review committee.

Active deception of subjects is considerably more controversial than simply withholding certain information. Lying to subjects is a tactic not commonly employed in biomedical research. Social and behavioural scientists, however, sometimes deliberately misinform subjects to study their attitudes and behaviour. For example, scientists have pretended to be patients to study the behaviour of health-care professionals and patients in their natural settings.

Some people maintain that active deception is never permissible. Others would permit it in certain circumstances. Deception is not permissible, however, in cases in which the deception itself would disguise the possibility of the subject being exposed to more than minimal risk. When deception is deemed indispensable to the methods of a study the investigators must demonstrate to an ethical review committee that no other research method would suffice; that significant advances could result from the research; and that nothing has been withheld that, if divulged, would cause a reasonable person to refuse to participate. The ethical review committee should determine the consequences for the subject of being deceived, and whether and how deceived subjects should be informed of the deception upon completion of the research. Such informing, commonly called "debriefing",

ordinarily entails explaining the reasons for the deception. A subject who disapproves of having been deceived should be offered an opportunity to refuse to allow the investigator to use information thus obtained. Investigators and ethical review committees should be aware that deceiving research subjects may wrong them as well as harm them; subjects may resent not having been informed when they learn that they have participated in a study under false pretences. In some studies there may be justification for deceiving persons other than the subjects by either withholding or disguising elements of information. Such tactics are often proposed, for example, for studies of the abuse of spouses or children. An ethical review committee must review and approve all proposals to deceive persons other than the subjects. Subjects are entitled to prompt and honest answers to their questions; the ethical review committee must determine for each study whether others who are to be deceived are similarly entitled.

**Intimidation and undue influence.** Intimidation in any form invalidates informed consent. Prospective subjects who are patients often depend for medical care upon the physician/investigator, who consequently has a certain credibility in their eyes, and whose influence over them may be considerable, particularly if the study protocol has a therapeutic component. They may fear, for example, that refusal to participate would damage the therapeutic relationship or result in the withholding of health services. The physician/investigator must assure them that their decision on whether to participate will not affect the therapeutic relationship or other benefits to which they are entitled. In this situation the ethical review committee should consider whether a neutral third party should seek informed consent.

The prospective subject must not be exposed to undue influence. The borderline between justifiable persuasion and undue influence is imprecise, however. The researcher should give no unjustifiable assurances about the benefits, risks or inconveniences of the research, for example, or induce a close relative or a community leader to influence a prospective subject's decision. (See also Guideline 4: *Individual informed consent.*)

**Risks.** Investigators should be completely objective in discussing the details of the experimental intervention, the pain and discomfort that it may entail, and known risks and possible hazards. In complex research projects it may be neither feasible nor desirable to inform prospective participants fully about every possible risk. They must, however, be informed of all risks that a 'reasonable person' would consider material to making a decision about whether to participate, including risks to a spouse or partner associated with trials of, for example, psychotropic or genital-tract medicaments. (See also Guideline 8 Commentary, *Risks to groups of persons.*)

**Exception to the requirement for informed consent in studies of emergency situations in which the researcher anticipates that many subjects will be unable to consent.** Research protocols are sometimes designed to address conditions occurring suddenly and rendering the patients/subjects incapable of giving informed consent. Examples are head trauma, cardiopulmonary arrest and stroke. The

investigation cannot be done with patients who can give informed consent in time and there may not be time to locate a person having the authority to give permission. In such circumstances it is often necessary to proceed with the research interventions very soon after the onset of the condition in order to evaluate an investigational treatment or develop the desired knowledge. As this class of emergency exception can be anticipated, the researcher must secure the review and approval of an ethical review committee before initiating the study. If possible, an attempt should be made to identify a population that is likely to develop the condition to be studied. This can be done readily, for example, if the condition is one that recurs periodically in individuals; examples include grand mal seizures and alcohol binges. In such cases, prospective subjects should be contacted while fully capable of informed consent, and invited to consent to their involvement as research subjects during future periods of incapacitation. If they are patients of an independent physician who is also the physician-researcher, the physician should likewise seek their consent while they are fully capable of informed consent. In all cases in which approved research has begun without prior consent of patients/subjects incapable of giving informed consent because of suddenly occurring conditions, they should be given all relevant information as soon as they are in a state to receive it, and their consent to continued participation should be obtained as soon as is reasonably possible.

Before proceeding without prior informed consent, the investigator must make reasonable efforts to locate an individual who has the authority to give permission on behalf of an incapacitated patient. If such a person can be located and refuses to give permission, the patient may not be enrolled as a subject. The risks of all interventions and procedures will be justified as required by Guideline 9 (Special limitations on risks when research involves individuals who are not capable of giving consent). The researcher and the ethical review committee should agree to a maximum time of involvement of an individual without obtaining either the individual's informed consent or authorization according to the applicable legal system if the person is not able to give consent. If by that time the researcher has not obtained either consent or permission – owing either to a failure to contact a representative or to a refusal of either the patient or the person or body authorized to give permission – the participation of the patient as a subject must be discontinued. The patient or the person or body providing authorization should be offered an opportunity to forbid the use of data derived from participation of the patient as a subject without consent or permission.

Where appropriate, plans to conduct emergency research without prior consent of the subjects should be publicized within the community in which it will be carried out. In the design and conduct of the research, the ethical review committee, the investigators and the sponsors should be responsive to the concerns of the community. If there is cause for concern about the acceptability of the research in the community, there should be a formal consultation with representatives designated by the community. The research should not be carried

out if it does not have substantial support in the community concerned. (See Guideline 8 *Commentary, Risks to groups of persons.*)

**Exception to the requirement of informed consent for inclusion in clinical trials of persons rendered incapable of informed consent by an acute condition.** Certain patients with an acute condition that renders them incapable of giving informed consent may be eligible for inclusion in a clinical trial in which the majority of prospective subjects will be capable of informed consent. Such a trial would relate to a new treatment for an acute condition such as sepsis, stroke or myocardial infarction. The investigational treatment would hold out the prospect of direct benefit and would be justified accordingly, though the investigation might involve certain procedures or interventions that were not of direct benefit but carried no more than minimal risk; an example would be the process of randomization or the collection of additional blood for research purposes. For such cases the initial protocol submitted for approval to the ethical review committee should anticipate that some patients may be incapable of consent, and should propose for such patients a form of proxy consent, such as permission of the responsible relative. When the ethical review committee has approved or cleared such a protocol, an investigator may seek the permission of the responsible relative and enrol such a patient.

#### **Guideline 7: Inducement to participate**

Subjects may be reimbursed for lost earnings, travel costs and other expenses incurred in taking part in a study; they may also receive free medical services. Subjects, particularly those who receive no direct benefit from research, may also be paid or otherwise compensated for inconvenience and time spent. The payments should not be so large, however, or the medical services so extensive as to induce prospective subjects to consent to participate in the research against their better judgment (“undue inducement”). All payments, reimbursements and medical services provided to research subjects must have been approved by an ethical review committee.

#### *Commentary on Guideline 7*

**Acceptable recompense.** Research subjects may be reimbursed for their transport and other expenses, including lost earnings, associated with their participation in research. Those who receive no direct benefit from the research may also receive a small sum of money for inconvenience due to their participation in the research. All subjects may receive medical services unrelated to the research and have procedures and tests performed free of charge.

**Unacceptable recompense.** Payments in money or in kind to research subjects should not be so large as to persuade them to take undue risks or volunteer against their better judgment. Payments or rewards that undermine a person’s capacity to exercise free choice invalidate consent. It may be difficult to distinguish between suitable recompense and undue influence to participate in research. An unemployed person or a student may view promised recompense

differently from an employed person. Someone without access to medical care may or may not be unduly influenced to participate in research simply to receive such care. A prospective subject may be induced to participate in order to obtain a better diagnosis or access to a drug not otherwise available; local ethical review committees may find such inducements acceptable. Monetary and in-kind recompense must, therefore, be evaluated in the light of the traditions of the particular culture and population in which they are offered, to determine whether they constitute undue influence. The ethical review committee will ordinarily be the best judge of what constitutes reasonable material recompense in particular circumstances. When research interventions or procedures that do not hold out the prospect of direct benefit present more than minimal risk, all parties involved in the research – sponsors, investigators and ethical review committees – in both funding and host countries should be careful to avoid undue material inducement.

**Incompetent persons.** Incompetent persons may be vulnerable to exploitation for financial gain by guardians. A guardian asked to give permission on behalf of an incompetent person should be offered no recompense other than a refund of travel and related expenses.

**Withdrawal from a study.** A subject who withdraws from research for reasons related to the study, such as unacceptable side-effects of a study drug, or who is withdrawn on health grounds, should be paid or recompensed as if full participation had taken place. A subject who withdraws for any other reason should be paid in proportion to the amount of participation. An investigator who must remove a subject from the study for wilful noncompliance is entitled to withhold part or all of the payment.

### **Guideline 8: Benefits and risks of study participation**

For all biomedical research involving human subjects, the investigator must ensure that potential benefits and risks are reasonably balanced and risks are minimized.

- Interventions or procedures that hold out the prospect of direct diagnostic, therapeutic or preventive benefit for the individual subject must be justified by the expectation that they will be at least as advantageous to the individual subject, in the light of foreseeable risks and benefits, as any available alternative. Risks of such ‘beneficial’ interventions or procedures must be justified in relation to expected benefits to the individual subject.

- Risks of interventions that do not hold out the prospect of direct diagnostic, therapeutic or preventive benefit for the individual must be justified in relation to the expected benefits to society (generalizable knowledge). The risks presented by such interventions must be reasonable in relation to the importance of the knowledge to be gained.

#### *Commentary on Guideline 8*

The Declaration of Helsinki in several paragraphs deals with the well-being of research subjects and the avoidance of risk. Thus, considerations related to the

well-being of the human subject should take precedence over the interests of science and society (Paragraph 5); clinical testing must be preceded by adequate laboratory or animal experimentation to demonstrate a reasonable probability of success without undue risk (Paragraph 11); every project should be preceded by careful assessment of predictable risks and burdens in comparison with foreseeable benefits to the subject or to others (Paragraph 16); physician-researchers must be confident that the risks involved have been adequately assessed and can be satisfactorily managed (Paragraph 17); and the risks and burdens to the subject must be minimized, and reasonable in relation to the importance of the objective or the knowledge to be gained (Paragraph 18).

Biomedical research often employs a variety of interventions of which some hold out the prospect of direct therapeutic benefit (beneficial interventions) and others are administered solely to answer the research question (non-beneficial interventions). Beneficial interventions are justified as they are in medical practice by the expectation that they will be at least as advantageous to the individuals concerned, in the light of both risks and benefits, as any available alternative. Non-beneficial interventions are assessed differently; they may be justified only by appeal to the knowledge to be gained. In assessing the risks and benefits that a protocol presents to a population, it is appropriate to consider the harm that could result from forgoing the research.

Paragraphs 5 and 18 of the Declaration of Helsinki do not preclude well-informed volunteers, capable of fully appreciating risks and benefits of an investigation, from participating in research for altruistic reasons or for modest remuneration.

**Minimizing risk associated with participation in a randomized controlled trial.** In randomized controlled trials subjects risk being allocated to receive the treatment that proves inferior. They are allocated by chance to one of two or more intervention arms and followed to a predetermined end-point. (Interventions are understood to include new or established therapies, diagnostic tests and preventive measures.) An intervention is evaluated by comparing it with another intervention (a control), which is ordinarily the best current method, selected from the safe and effective treatments available globally, unless some other control intervention such as placebo can be justified ethically (See Guideline 11).

To minimize risk when the intervention to be tested in a randomized controlled trial is designed to prevent or postpone a lethal or disabling outcome, the investigator must not, for purposes of conducting the trial, withhold therapy that is known to be superior to the intervention being tested, unless the withholding can be justified by the standards set forth in Guideline 11. Also, the investigator must provide in the research protocol for the monitoring of research data by an independent board (Data and Safety Monitoring Board); one function of such a board is to protect the research subjects from previously unknown adverse reactions or unnecessarily prolonged exposure to an inferior therapy. Normally at the outset of a randomized controlled trial, criteria are established for its premature termination (stopping rules or guidelines).

**Risks to groups of persons.** Research in certain fields, such as epidemiology, genetics or sociology, may present risks to the interests of communities, societies, or racially or ethnically defined groups. Information might be published that could stigmatize a group or expose its members to discrimination. Such information, for example, could indicate, rightly or wrongly, that the group has a higher than average prevalence of alcoholism, mental illness or sexually transmitted disease, or is particularly susceptible to certain genetic disorders. Plans to conduct such research should be sensitive to such considerations, to the need to maintain confidentiality during and after the study, and to the need to publish the resulting data in a manner that is respectful of the interests of all concerned, or in certain circumstances not to publish them. The ethical review committee should ensure that the interests of all concerned are given due consideration; often it will be advisable to have individual consent supplemented by community consultation.

[The ethical basis for the justification of risk is elaborated further in Guideline 9]

**Guideline 9: Special limitations on risk when research involves individuals who are not capable of giving informed consent**

When there is ethical and scientific justification to conduct research with individuals incapable of giving informed consent, the risk from research interventions that do not hold out the prospect of direct benefit for the individual subject should be no more likely and not greater than the risk attached to routine medical or psychological examination of such persons. Slight or minor increases above such risk may be permitted when there is an overriding scientific or medical rationale for such increases and when an ethical review committee has approved them.

*Commentary on Guideline 9*

**The low-risk standard:** Certain individuals or groups may have limited capacity to give informed consent either because, as in the case of prisoners, their autonomy is limited, or because they have limited cognitive capacity. For research involving persons who are unable to consent, or whose capacity to make an informed choice may not fully meet the standard of informed consent, ethical review committees must distinguish between intervention risks that do not exceed those associated with routine medical or psychological examination of such persons and risks in excess of those.

When the risks of such interventions do not exceed those associated with routine medical or psychological examination of such persons, there is no requirement for special substantive or procedural protective measures apart from those generally required for all research involving members of the particular class of persons. When the risks are in excess of those, the ethical review committee must find:

1. that the research is designed to be responsive to the disease affecting the prospective subjects or to conditions to which they are particularly susceptible;

2. that the risks of the research interventions are only slightly greater than those associated with routine medical or psychological examination of such persons for the condition or set of clinical circumstances under investigation;
3. that the objective of the research is sufficiently important to justify exposure of the subjects to the increased risk; and
4. that the interventions are reasonably commensurate with the clinical interventions that the subjects have experienced or may be expected to experience in relation to the condition under investigation.

If such research subjects, including children, become capable of giving independent informed consent during the research, their consent to continued participation should be obtained.

There is no internationally agreed, precise definition of a “slight or minor increase” above the risks associated with routine medical or psychological examination of such persons. Its meaning is inferred from what various ethical review committees have reported as having met the standard. Examples include additional lumbar punctures or bone-marrow aspirations in children with conditions for which such examinations are regularly indicated in clinical practice. The requirement that the objective of the research be relevant to the disease or condition affecting the prospective subjects rules out the use of such interventions in healthy children.

The requirement that the research interventions be reasonably commensurate with clinical interventions that subjects may have experienced or are likely to experience for the condition under investigation is intended to enable them to draw on personal experience as they decide whether to accept or reject additional procedures for research purposes. Their choices will, therefore, be more informed even though they may not fully meet the standard of informed consent.

(See also Guidelines 4: *Individual informed consent*; 13: *Research involving vulnerable persons*; 14: *Research involving children*; and 15: *Research involving individuals who by reason of mental or behavioural disorders are not capable of giving adequately informed consent*.)

#### **Guideline 10: Research in populations and communities with limited resources**

Before undertaking research in a population or community with limited resources, the sponsor and the investigator must make every effort to ensure that:

- the research is responsive to the health needs and the priorities of the population or community in which it is to be carried out; and
- any intervention or product developed, or knowledge generated, will be made reasonably available for the benefit of that population or community.

#### *Commentary on Guideline 10*

This guideline is concerned with countries or communities in which resources are limited to the extent that they are, or may be, vulnerable to exploitation by sponsors and investigators from the relatively wealthy countries and communities.

**Responsiveness of research to health needs and priorities.** The ethical requirement that research be responsive to the health needs of the population or community in which it is carried out calls for decisions on what is needed to fulfil the requirement. It is not sufficient simply to determine that a disease is prevalent in the population and that new or further research is needed: the ethical requirement of “responsiveness” can be fulfilled only if successful interventions or other kinds of health benefit are made available to the population. This is applicable especially to research conducted in countries where governments lack the resources to make such products or benefits widely available. Even when a product to be tested in a particular country is much cheaper than the standard treatment in some other countries, the government or individuals in that country may still be unable to afford it. If the knowledge gained from the research in such a country is used primarily for the benefit of populations that can afford the tested product, the research may rightly be characterized as exploitative and, therefore, unethical.

When an investigational intervention has important potential for health care in the host country, the negotiation that the sponsor should undertake to determine the practical implications of “responsiveness”, as well as “reasonable availability”, should include representatives of stakeholders in the host country; these include the national government, the health ministry, local health authorities, and concerned scientific and ethics groups, as well as representatives of the communities from which subjects are drawn and non-governmental organizations such as health advocacy groups. The negotiation should cover the health-care infrastructure required for safe and rational use of the intervention, the likelihood of authorization for distribution, and decisions regarding payments, royalties, subsidies, technology and intellectual property, as well as distribution costs, when this economic information is not proprietary. In some cases, satisfactory discussion of the availability and distribution of successful products will necessarily engage international organizations, donor governments and bilateral agencies, international nongovernmental organizations, and the private sector. The development of a health-care infrastructure should be facilitated at the onset so that it can be of use during and beyond the conduct of the research.

Additionally, if an investigational drug has been shown to be beneficial, the sponsor should continue to provide it to the subjects after the conclusion of the study, and pending its approval by a drug regulatory authority. The sponsor is unlikely to be in a position to make a beneficial investigational intervention generally available to the community or population until some time after the conclusion of the study, as it may be in short supply and in any case cannot be made generally available before a drug regulatory authority has approved it.

For minor research studies and when the outcome is scientific knowledge rather than a commercial product, such complex planning or negotiation is rarely, if ever, needed. There must be assurance, however, that the scientific knowledge developed will be used for the benefit of the population.

**Reasonable availability.** The issue of “reasonable availability” is complex and will need to be determined on a case-by-case basis. Relevant considerations include the length of time for which the intervention or product developed, or other agreed benefit, will be made available to research subjects, or to the community or population concerned; the severity of a subject’s medical condition; the effect of withdrawing the study drug (e.g., death of a subject); the cost to the subject or health service; and the question of undue inducement if an intervention is provided free of charge.

In general, if there is good reason to believe that a product developed or knowledge generated by research is unlikely to be reasonably available to, or applied to the benefit of, the population of a proposed host country or community after the conclusion of the research, it is unethical to conduct the research in that country or community. This should not be construed as precluding studies designed to evaluate novel therapeutic concepts. As a rare exception, for example, research may be designed to obtain preliminary evidence that a drug or a class of drugs has a beneficial effect in the treatment of a disease that occurs only in regions with extremely limited resources, and it could not be carried out reasonably well in more developed communities. Such research may be justified ethically even if there is no plan in place to make a product available to the population of the host country or community at the conclusion of the preliminary phase of its development. If the concept is found to be valid, subsequent phases of the research could result in a product that could be made reasonably available at its conclusion.

(See also Guidelines 3: *Ethical review of externally sponsored research*; 12, *Equitable distribution of burdens and benefits*; 20: *Strengthening capacity for ethical and scientific review and biomedical research*; and 21: *Ethical obligation of external sponsors to provide health-care services*.)

#### **Guideline 11: Choice of control in clinical trials**

As a general rule, research subjects in the control group of a trial of a diagnostic, therapeutic, or preventive intervention should receive an established effective intervention. In some circumstances it may be ethically acceptable to use an alternative comparator, such as placebo or “no treatment”.

- Placebo may be used:
  - when there is no established effective intervention;
  - when withholding an established effective intervention would expose subjects to, at most, temporary discomfort or delay in relief of symptoms;
  - when use of an established effective intervention as comparator would not yield scientifically reliable results and use of placebo would not add any risk of serious or irreversible harm to the subjects.

#### *Commentary on Guideline 11*

General considerations for controlled clinical trials. The design of trials of investigational diagnostic, therapeutic or preventive interventions raises interrelated

scientific and ethical issues for sponsors, investigators and ethical review committees. To obtain reliable results, investigators must compare the effects of an investigational intervention on subjects assigned to the investigational arm (or arms) of a trial with the effects that a control intervention produces in subjects drawn from the same population and assigned to its control arm. Randomization is the preferred method for assigning subjects to the various arms of the clinical trial unless another method, such as historical or literature controls, can be justified scientifically and ethically. Assignment to treatment arms by randomization, in addition to its usual scientific superiority, offers the advantage of tending to render equivalent to all subjects the foreseeable benefits and risks of participation in a trial.

A clinical trial cannot be justified ethically unless it is capable of producing scientifically reliable results. When the objective is to establish the effectiveness and safety of an investigational intervention, the use of a placebo control is often much more likely than that of an active control to produce a scientifically reliable result. In many cases the ability of a trial to distinguish effective from ineffective interventions (its assay sensitivity) cannot be assured unless the control is a placebo. If, however, an effect of using a placebo would be to deprive subjects in the control arm of an established effective intervention, and thereby to expose them to serious harm, particularly if it is irreversible, it would obviously be unethical to use a placebo.

**Placebo control in the absence of a current effective alternative.** The use of placebo in the control arm of a clinical trial is ethically acceptable when, as stated in the Declaration of Helsinki (Paragraph 29), “no proven prophylactic, diagnostic or therapeutic method exists.” Usually, in this case, a placebo is scientifically preferable to no intervention. In certain circumstances, however, an alternative design may be both scientifically and ethically acceptable, and preferable; an example would be a clinical trial of a surgical intervention, because, for many surgical interventions, either it is not possible or it is ethically unacceptable to devise a suitable placebo; for another example, in certain vaccine trials an investigator might choose to provide for those in the ‘control’ arm a vaccine that is unrelated to the investigational vaccine.

**Placebo-controlled trials that entail only minor risks.** A placebo-controlled design may be ethically acceptable, and preferable on scientific grounds, when the condition for which patients/subjects are randomly assigned to placebo or active treatment is only a small deviation in physiological measurements, such as slightly raised blood pressure or a modest increase in serum cholesterol; and if delaying or omitting available treatment may cause only temporary discomfort (e.g., common headache) and no serious adverse consequences. The ethical review committee must be fully satisfied that the risks of withholding an established effective intervention are truly minor and short-lived.

**Placebo control when active control would not yield reliable results.** A related but distinct rationale for using a placebo control rather than an established effective intervention is that the documented experience with the established effective intervention is not sufficient to provide a scientifically reliable comparison with the

intervention being investigated; it is then difficult, or even impossible, without using a placebo, to design a scientifically reliable study. This is not always, however, an ethically acceptable basis for depriving control subjects of an established effective intervention in clinical trials; only when doing so would not add any risk of serious harm, particularly irreversible harm, to the subjects would it be ethically acceptable to do so. In some cases, the condition at which the intervention is aimed (for example, cancer or HIV/AIDS) will be too serious to deprive control subjects of an established effective intervention.

This latter rationale (*when active control would not yield reliable results*) differs from the former (*trials that entail only minor risks*) in emphasis. In trials that entail only minor risks the investigative interventions are aimed at relatively trivial conditions, such as the common cold or hair loss; forgoing an established effective intervention for the duration of a trial deprives control subjects of only minor benefits. It is for this reason that it is not unethical to use a placebo-control design. Even if it were possible to design a so-called “non-inferiority”, or “equivalency”, trial using an active control, it would still not be unethical in these circumstances to use a placebo-control design. In any event, the researcher must satisfy the ethical review committee that the safety and human rights of the subjects will be fully protected, that prospective subjects will be fully informed about alternative treatments, and that the purpose and design of the study are scientifically sound. The ethical acceptability of such placebo-controlled studies increases as the period of placebo use is decreased, and when the study design permits change to active treatment (“escape treatment”) if intolerable symptoms occur.

**Exceptional use of a comparator other than an established effective intervention.**

An exception to the general rule is applicable in some studies designed to develop a therapeutic, preventive or diagnostic intervention for use in a country or community in which an established effective intervention is not available and unlikely in the foreseeable future to become available, usually for economic or logistic reasons. The purpose of such a study is to make available to the population of the country or community an effective alternative to an established effective intervention that is locally unavailable. Accordingly, the proposed investigational intervention must be responsive to the health needs of the population from which the research subjects are recruited and there must be assurance that, if it proves to be safe and effective, it will be made reasonably available to that population. Also, the scientific and ethical review committees must be satisfied that the established effective intervention cannot be used as comparator because its use would not yield scientifically reliable results that would be relevant to the health needs of the study population. In these circumstances an ethical review committee can approve a clinical trial in which the comparator is other than an established effective intervention, such as placebo or no treatment or a local remedy. However, some people strongly object to the exceptional use of a comparator other than an established effective intervention because it could result in exploitation of poor and disadvantaged populations. The objection rests on three arguments:

- Placebo control could expose research subjects to risk of serious or irreversible harm when the use of an established effective intervention as comparator could avoid the risk.
- Not all scientific experts agree about conditions under which an established effective intervention used as a comparator would not yield scientifically reliable results.
- An economic reason for the unavailability of an established effective intervention cannot justify a placebo-controlled study in a country of limited resources when it would be unethical to conduct a study with the same design in a population with general access to the effective intervention outside the study.

**Placebo control when an established effective intervention is not available in the host country.** The question addressed here is: when should an exception be allowed to the general rule that subjects in the control arm of a clinical trial should receive an established effective intervention?

The usual reason for proposing the exception is that, for economic or logistic reasons, an established effective intervention is not in general use or available in the country in which the study will be conducted, whereas the investigational intervention could be made available, given the finances and infrastructure of the country.

Another reason that may be advanced for proposing a placebo-controlled trial is that using an established effective intervention as the control would not produce scientifically reliable data relevant to the country in which the trial is to be conducted. Existing data about the effectiveness and safety of the established effective intervention may have been accumulated under circumstances unlike those of the population in which it is proposed to conduct the trial; this, it may be argued, could make their use in the trial unreliable. One reason could be that the disease or condition manifests itself differently in different populations, or other uncontrolled factors could invalidate the use of existing data for comparative purposes.

The use of placebo control in these circumstances is ethically controversial, for the following reasons:

- Sponsors of research might use poor countries or communities as testing grounds for research that would be difficult or impossible in countries where there is general access to an established effective intervention, and the investigational intervention, if proven safe and effective, is likely to be marketed in countries in which an established effective intervention is already available and it is not likely to be marketed in the host country.
- The research subjects, both active-arm and control-arm, are patients who may have a serious, possibly life-threatening, illness. They do not normally have access to an established effective intervention currently available to similar patients in many other countries. According to the requirements of a scientifically reliable trial, investigators, who may be their attending physicians, would be expected to enrol some of those patients/subjects in the placebo-control arm. This would appear to be a violation of the physician's fiduciary duty of undivided loyalty to the patient, particularly in cases in which known effective therapy could be made available to the patients.

An argument for exceptional use of placebo control may be that a health authority in a country where an established effective intervention is not generally available or affordable, and unlikely to become available or affordable in the foreseeable future, seeks to develop an affordable intervention specifically for a health problem affecting its population. There may then be less reason for concern that a placebo design is exploitative, and therefore unethical, as the health authority has responsibility for the population's health, and there are valid health grounds for testing an apparently beneficial intervention. In such circumstances an ethical review committee may determine that the proposed trial is ethically acceptable, provided that the rights and safety of subjects are safeguarded.

Ethical review committees will need to engage in careful analysis of the circumstances to determine whether the use of placebo rather than an established effective intervention is ethically acceptable. They will need to be satisfied that an established effective intervention is truly unlikely to become available and implementable in that country. This may be difficult to determine, however, as it is clear that, with sufficient persistence and ingenuity, ways may be found of accessing previously unattainable medicinal products, and thus avoiding the ethical issue raised by the use of placebo control.

When the rationale of proposing a placebo-controlled trial is that the use of an established effective intervention as the control would not yield scientifically reliable data relevant to the proposed host country, the ethical review committee in that country has the option of seeking expert opinion as to whether use of an established effective intervention in the control arm would invalidate the results of the research.

**An “equivalency trial” as an alternative to a placebo-controlled trial.** An alternative to a placebo-control design in these circumstances would be an “equivalency trial”, which would compare an investigational intervention with an established effective intervention and produce scientifically reliable data. An equivalency trial in a country in which no established effective intervention is available is not designed to determine whether the investigational intervention is superior to an established effective intervention currently used somewhere in the world; its purpose is, rather, to determine whether the investigational intervention is, in effectiveness and safety, equivalent to, or almost equivalent to, the established effective intervention. It would be hazardous to conclude, however, that an intervention demonstrated to be equivalent, or almost equivalent, to an established effective intervention is better than nothing or superior to whatever intervention is available in the country; there may be substantial differences between the results of superficially identical clinical trials carried out in different countries. If there are such differences, it would be scientifically acceptable and ethically preferable to conduct such ‘equivalency’ trials in countries in which an established effective intervention is already available.

If there are substantial grounds for the ethical review committee to conclude that an established effective intervention will not become available and

implementable, the committee should obtain assurances from the parties concerned that plans have been agreed for making the investigational intervention reasonably available in the host country or community once its effectiveness and safety have been established. Moreover, when the study has external sponsorship, approval should usually be dependent on the sponsors and the health authorities of the host country having engaged in a process of negotiation and planning, including justifying the study in regard to local health-care needs.

**Means of minimizing harm to placebo-control subjects.** Even when placebo controls are justified on one of the bases set forth in the guideline, there are means of minimizing the possibly harmful effect of being in the control arm.

First, a placebo-control group need not be untreated. An add-on design may be employed when the investigational therapy and a standard treatment have different mechanisms of action. The treatment to be tested and placebo are each added to a standard treatment. Such studies have a particular place when a standard treatment is known to decrease mortality or irreversible morbidity but a trial with standard treatment as the active control cannot be carried out or would be difficult to interpret [*International Conference on Harmonisation (ICH) Guideline: Choice of Control Group and Related Issues in Clinical Trials, 2000*]. In testing for improved treatment of life-threatening diseases such as cancer, HIV/AIDS, or heart failure, add-on designs are a particularly useful means of finding improvements in interventions that are not fully effective or may cause intolerable side-effects. They have a place also in respect of treatment for epilepsy, rheumatism and osteoporosis, for example, because withholding of established effective therapy could result in progressive disability, unacceptable discomfort or both.

Second, as indicated in Guideline 8 Commentary, when the intervention to be tested in a randomized controlled trial is designed to prevent or postpone a lethal or disabling outcome, the investigator minimizes harmful effects of placebo-control studies by providing in the research protocol for the monitoring of research data by an independent Data and Safety Monitoring Board (DSMB). One function of such a board is to protect the research subjects from previously unknown adverse reactions; another is to avoid unnecessarily prolonged exposure to an inferior therapy. The board fulfils the latter function by means of interim analyses of the data pertaining to efficacy to ensure that the trial does not continue beyond the point at which an investigational therapy is demonstrated to be effective. Normally, at the outset of a randomized controlled trial, criteria are established for its premature termination (stopping rules or guidelines).

In some cases the DSMB is called upon to perform “conditional power calculations”, designed to determine the probability that a particular clinical trial could ever show that the investigational therapy is effective. If that probability is very small, the DSMB is expected to recommend termination of the clinical trial, because it would be unethical to continue it beyond that point.

In most cases of research involving human subjects, it is unnecessary to appoint a DSMB. To ensure that research is carefully monitored for the early

detection of adverse events, the sponsor or the principal investigator appoints an individual to be responsible for advising on the need to consider changing the system of monitoring for adverse events or the process of informed consent, or even to consider terminating the study.

**Guideline 12: Equitable distribution of burdens and benefits in the selection of groups of subjects in research**

Groups or communities to be invited to be subjects of research should be selected in such a way that the burdens and benefits of the research will be equitably distributed. The exclusion of groups or communities that might benefit from study participation must be justified.

*Commentary on Guideline 12*

**General considerations:** Equity requires that no group or class of persons should bear more than its fair share of the burdens of participation in research. Similarly, no group should be deprived of its fair share of the benefits of research, short-term or long-term; such benefits include the direct benefits of participation as well as the benefits of the new knowledge that the research is designed to yield. When burdens or benefits of research are to be apportioned unequally among individuals or groups of persons, the criteria for unequal distribution should be morally justifiable and not arbitrary. In other words, unequal allocation must not be inequitable. Subjects should be drawn from the qualifying population in the general geographic area of the trial without regard to race, ethnicity, economic status or gender unless there is a sound scientific reason to do otherwise.

In the past, groups of persons were excluded from participation in research for what were then considered good reasons. As a consequence of such exclusions, information about the diagnosis, prevention and treatment of diseases in such groups of persons is limited. This has resulted in a serious class injustice. If information about the management of diseases is considered a benefit that is distributed within a society, it is unjust to deprive groups of persons of that benefit. Such documents as the Declaration of Helsinki and the UNAIDS Guidance Document *Ethical Considerations in HIV Preventive Vaccine Research*, and the policies of many national governments and professional societies, recognize the need to redress these injustices by encouraging the participation of previously excluded groups in basic and applied biomedical research.

Members of vulnerable groups also have the same entitlement to access to the benefits of investigational interventions that show promise of therapeutic benefit as persons not considered vulnerable, particularly when no superior or equivalent approaches to therapy are available.

There has been a perception, sometimes correct and sometimes incorrect, that certain groups of persons have been overused as research subjects. In some cases such overuse has been based on the administrative availability of the populations. Research hospitals are often located in places where members of

the lowest socioeconomic classes reside, and this has resulted in an apparent overuse of such persons. Other groups that may have been overused because they were conveniently available to researchers include students in investigators' classes, residents of long-term care facilities and subordinate members of hierarchical institutions. Impoverished groups have been overused because of their willingness to serve as subjects in exchange for relatively small stipends. Prisoners have been considered ideal subjects for Phase I drug studies because of their highly regimented lives and, in many cases, their conditions of economic deprivation.

Overuse of certain groups, such as the poor or the administratively available, is unjust for several reasons. It is unjust to selectively recruit impoverished people to serve as research subjects simply because they can be more easily induced to participate in exchange for small payments. In most cases, these people would be called upon to bear the burdens of research so that others who are better off could enjoy the benefits. However, although the burdens of research should not fall disproportionately on socio-economically disadvantaged groups, neither should such groups be categorically excluded from research protocols. It would not be unjust to selectively recruit poor people to serve as subjects in research designed to address problems that are prevalent in their group – malnutrition, for example. Similar considerations apply to institutionalized groups or those whose availability to the investigators is for other reasons administratively convenient.

Not only may certain groups within a society be inappropriately overused as research subjects, but also entire communities or societies may be overused. This has been particularly likely to occur in countries or communities with insufficiently well-developed systems for the protection of the rights and welfare of human research subjects. Such overuse is especially questionable when the populations or communities concerned bear the burdens of participation in research but are extremely unlikely ever to enjoy the benefits of new knowledge and products developed as a result of the research. (See *Guideline 10: Research in populations and communities with limited resources.*)

### **Guideline 13: Research involving vulnerable persons**

Special justification is required for inviting vulnerable individuals to serve as research subjects and, if they are selected, the means of protecting their rights and welfare must be strictly applied.

#### *Commentary on Guideline 13*

Vulnerable persons are those who are relatively (or absolutely) incapable of protecting their own interests. More formally, they may have insufficient power, intelligence, education, resources, strength, or other needed attributes to protect their own interests.

**General considerations.** The central problem presented by plans to involve vulnerable persons as research subjects is that such plans may entail an inequitable

distribution of the burdens and benefits of research participation. Classes of individuals conventionally considered vulnerable are those with limited capacity or freedom to consent or to decline to consent. They are the subject of specific guidelines in this document (Guidelines 14,15) and include children, and persons who because of mental or behavioural disorders are incapable of giving informed consent. Ethical justification of their involvement usually requires that investigators satisfy ethical review committees that:

- the research could not be carried out equally well with less vulnerable subjects;
- the research is intended to obtain knowledge that will lead to improved diagnosis, prevention or treatment of diseases or other health problems characteristic of, or unique to, the vulnerable class – either the actual subjects or other similarly situated members of the vulnerable class;
- research subjects and other members of the vulnerable class from which subjects are recruited will ordinarily be assured reasonable access to any diagnostic, preventive or therapeutic products that will become available as a consequence of the research;
- the risks attached to interventions or procedures that do not hold out the prospect of direct health-related benefit will not exceed those associated with routine medical or psychological examination of such persons unless an ethical review committee authorizes a slight increase over this level of risk (Guideline 9); and,
- when the prospective subjects are either incompetent or otherwise substantially unable to give informed consent, their agreement will be supplemented by the permission of their legal guardians or other appropriate representatives.

**Other vulnerable groups.** The quality of the consent of prospective subjects who are junior or subordinate members of a hierarchical group requires careful consideration, as their agreement to volunteer may be unduly influenced, whether justified or not, by the expectation of preferential treatment if they agree or by fear of disapproval or retaliation if they refuse. Examples of such groups are medical and nursing students, subordinate hospital and laboratory personnel, employees of pharmaceutical companies, and members of the armed forces or police. Because they work in close proximity to investigators, they tend to be called upon more often than others to serve as research subjects, and this could result in inequitable distribution of the burdens and benefits of research.

**Elderly persons are commonly regarded as vulnerable.** With advancing age, people are increasingly likely to acquire attributes that define them as vulnerable. They may, for example, be institutionalized or develop varying degrees of dementia. If and when they acquire such vulnerability-defining attributes, and not before, it is appropriate to consider them vulnerable and to treat them accordingly.

**Other groups or classes may also be considered vulnerable.** They include residents of nursing homes, people receiving welfare benefits or social assistance and other poor people and the unemployed, patients in emergency rooms, some ethnic and racial minority groups, homeless persons, nomads, refugees or displaced persons,

prisoners, patients with incurable disease, individuals who are politically powerless, and members of communities unfamiliar with modern medical concepts. To the extent that these and other classes of people have attributes resembling those of classes identified as vulnerable, the need for special protection of their rights and welfare should be reviewed and applied, where relevant.

**Persons who have serious, potentially disabling or life-threatening diseases are highly vulnerable.** Physicians sometimes treat such patients with drugs or other therapies not yet licensed for general availability because studies designed to establish their safety and efficacy have not been completed. This is compatible with the Declaration of Helsinki, which states in Paragraph 32: *“In the treatment of a patient, where proven...therapeutic methods do not exist or have been ineffective, the physician, with informed consent from the patient, must be free to use unproven or new... therapeutic measures, if in the physician’s judgement it offers hope of saving life, re-establishing health or alleviating suffering”*. Such treatment, commonly called ‘compassionate use’, is not properly regarded as research, but it can contribute to ongoing research into the safety and efficacy of the interventions used.

Although, on the whole, investigators must study less vulnerable groups before involving more vulnerable groups, some exceptions are justified. In general, children are not suitable for Phase I drug trials or for Phase I or II vaccine trials, but such trials may be permissible after studies in adults have shown some therapeutic or preventive effect. For example, a Phase II vaccine trial seeking evidence of immunogenicity in infants may be justified when a vaccine has shown evidence of preventing or slowing progression of an infectious disease in adults, or Phase I research with children may be appropriate because the disease to be treated does not occur in adults or is manifested differently in children (Appendix 3: The phases of clinical trials of vaccines and drugs).

#### **Guideline 14: Research involving children**

Before undertaking research involving children, the investigator must ensure that:

- the research might not equally well be carried out with adults;
- the purpose of the research is to obtain knowledge relevant to the health needs of children;
- a parent or legal representative of each child has given permission;
- the agreement (assent) of each child has been obtained to the extent of the child’s capabilities; and,
- a child’s refusal to participate or continue in the research will be respected.

#### *Commentary on Guideline 14*

**Justification of the involvement of children in biomedical research.** The participation of children is indispensable for research into diseases of childhood and conditions to which children are particularly susceptible (cf. vaccine trials), as well as for clinical trials of drugs that are designed for children as well as adults. In

the past, many new products were not tested for children though they were directed towards diseases also occurring in childhood; thus children either did not benefit from these new drugs or were exposed to them though little was known about their specific effects or safety in children. Now it is widely agreed that, as a general rule, the sponsor of any new therapeutic, diagnostic or preventive product that is likely to be indicated for use in children is obliged to evaluate its safety and efficacy for children before it is released for general distribution.

Assent of the child. The willing cooperation of the child should be sought, after the child has been informed to the extent that the child's maturity and intelligence permit. The age at which a child becomes legally competent to give consent differs substantially from one jurisdiction to another; in some countries the "age of consent" established in their different provinces, states or other political subdivisions varies considerably. Often children who have not yet reached the legally established age of consent can understand the implications of informed consent and go through the necessary procedures; they can therefore knowingly agree to serve as research subjects. Such knowing agreement, sometimes referred to as assent, is insufficient to permit participation in research unless it is supplemented by the permission of a parent, a legal guardian or other duly authorized representative.

Some children who are too immature to be able to give knowing agreement, or assent, may be able to register a 'deliberate objection', an expression of disapproval or refusal of a proposed procedure. The deliberate objection of an older child, for example, is to be distinguished from the behaviour of an infant, who is likely to cry or withdraw in response to almost any stimulus. Older children, who are more capable of giving assent, should be selected before younger children or infants, unless there are valid scientific reasons related to age for involving younger children first.

A deliberate objection by a child to taking part in research should always be respected even if the parents have given permission, unless the child needs treatment that is not available outside the context of research, the investigational intervention shows promise of therapeutic benefit, and there is no acceptable alternative therapy. In such a case, particularly if the child is very young or immature, a parent or guardian may override the child's objections. If the child is older and more nearly capable of independent informed consent, the investigator should seek the specific approval or clearance of the scientific and ethical review committees for initiating or continuing with the investigational treatment. If child subjects become capable of independent informed consent during the research, their informed consent to continued participation should be sought and their decision respected.

A child with a likely fatal illness may object or refuse assent to continuation of a burdensome or distressing intervention. In such circumstances parents may press an investigator to persist with an investigational intervention against the child's wishes. The investigator may agree to do so if the intervention shows promise of preserving or prolonging life and there is no acceptable alternative treatment. In such cases, the investigator should seek the specific approval or clearance of the ethical review committee before agreeing to override the wishes of the child.

**Permission of a parent or guardian.** The investigator must obtain the permission of a parent or guardian in accordance with local laws or established procedures. It may be assumed that children over the age of 12 or 13 years are usually capable of understanding what is necessary to give adequately informed consent, but their consent (assent) should normally be complemented by the permission of a parent or guardian, even when local law does not require such permission. Even when the law requires parental permission, however, the assent of the child must be obtained.

In some jurisdictions, some individuals who are below the general age of consent are regarded as “emancipated” or “mature” minors and are authorized to consent without the agreement or even the awareness of their parents or guardians. They may be married or pregnant or be already parents or living independently. Some studies involve investigation of adolescents’ beliefs and behaviour regarding sexuality or use of recreational drugs; other research addresses domestic violence or child abuse. For studies on these topics, ethical review committees may waive parental permission if, for example, parental knowledge of the subject matter may place the adolescents at some risk of questioning or even intimidation by their parents.

Because of the issues inherent in obtaining assent from children in institutions, such children should only exceptionally be subjects of research. In the case of institutionalized children without parents, or whose parents are not legally authorized to grant permission, the ethical review committee may require sponsors or investigators to provide it with the opinion of an independent, concerned, expert advocate for institutionalized children as to the propriety of undertaking the research with such children.

**Observation of research by a parent or guardian.** A parent or guardian who gives permission for a child to participate in research should be given the opportunity, to a reasonable extent, to observe the research as it proceeds, so as to be able to withdraw the child if the parent or guardian decides it is in the child’s best interests to do so.

**Psychological and medical support.** Research involving children should be conducted in settings in which the child and the parent can obtain adequate medical and psychological support. As an additional protection for children, an investigator may, when possible, obtain the advice of a child’s family physician, paediatrician or other health-care provider on matters concerning the child’s participation in the research.

(See also Guideline 8: *Benefits and risks of study participation*; Guideline 9: *Special limitations on risks when subjects are not capable of giving consent*; and Guideline 13: *Research involving vulnerable persons*.)

**Guideline 15: Research involving individuals who by reason of mental or behavioural disorders are not capable of giving adequately informed consent**

Before undertaking research involving individuals who by reason of mental or behavioural disorders are not capable of giving adequately informed consent, the investigator must ensure that:

- such persons will not be subjects of research that might equally well be carried out on persons whose capacity to give adequately informed consent is not impaired;
- the purpose of the research is to obtain knowledge relevant to the particular health needs of persons with mental or behavioural disorders;
- the consent of each subject has been obtained to the extent of that person's capabilities, and a prospective subject's refusal to participate in research is always respected, unless, in exceptional circumstances, there is no reasonable medical alternative and local law permits overriding the objection; and,
- in cases where prospective subjects lack capacity to consent, permission is obtained from a responsible family member or a legally authorized representative in accordance with applicable law.

*Commentary on Guideline 15*

**General considerations.** Most individuals with mental or behavioural disorders are capable of giving informed consent; this Guideline is concerned only with those who are not capable or who because their condition deteriorates become temporarily incapable. They should never be subjects of research that might equally well be carried out on persons in full possession of their mental faculties, but they are clearly the only subjects suitable for a large part of research into the origins and treatment of certain severe mental or behavioural disorders.

**Consent of the individual.** The investigator must obtain the approval of an ethical review committee to include in research persons who by reason of mental or behavioural disorders are not capable of giving informed consent. The willing cooperation of such persons should be sought to the extent that their mental state permits, and any objection on their part to taking part in any study that has no components designed to benefit them directly should always be respected. The objection of such an individual to an investigational intervention intended to be of therapeutic benefit should be respected unless there is no reasonable medical alternative and local law permits overriding the objection. The agreement of an immediate family member or other person with a close personal relationship with the individual should be sought, but it should be recognized that these proxies may have their own interests that may call their permission into question. Some relatives may not be primarily concerned with protecting the rights and welfare of the patients. Moreover, a close family member or friend may wish to take advantage of a research study in the hope that it will succeed in "curing" the condition. Some jurisdictions do not permit third-party permission for subjects lacking capacity to consent. Legal authorization may be necessary to involve in research an individual who has been committed to an institution by a court order.

Serious illness in persons who because of mental or behavioural disorders are unable to give adequately informed consent. Persons who because of mental or behavioural disorders are unable to give adequately informed consent and who have, or are at risk of, serious illnesses such as HIV infection, cancer or hepatitis should not be deprived of the possible benefits of investigational drugs, vaccines or

devices that show promise of therapeutic or preventive benefit, particularly when no superior or equivalent therapy or prevention is available. Their entitlement to access to such therapy or prevention is justified ethically on the same grounds as is such entitlement for other vulnerable groups.

Persons who are unable to give adequately informed consent by reason of mental or behavioural disorders are, in general, not suitable for participation in formal clinical trials except those trials that are designed to be responsive to their particular health needs and can be carried out only with them.

(See also Guidelines 8: *Benefits and risks of study participation*; 9: *Special limitations on risks when subjects are not capable of giving consent*; and 13: *Research involving vulnerable persons*.)

### **Guideline 16: Women as research subjects**

Investigators, sponsors or ethical review committees should not exclude women of reproductive age from biomedical research. The potential for becoming pregnant during a study should not, in itself, be used as a reason for precluding or limiting participation. However, a thorough discussion of risks to the pregnant woman and to her fetus is a prerequisite for the woman's ability to make a rational decision to enrol in a clinical study. In this discussion, if participation in the research might be hazardous to a fetus or a woman if she becomes pregnant, the sponsors/investigators should guarantee the prospective subject a pregnancy test and access to effective contraceptive methods before the research commences. Where such access is not possible, for legal or religious reasons, investigators should not recruit for such possibly hazardous research women who might become pregnant.

#### *Commentary on Guideline 16*

Women in most societies have been discriminated against with regard to their involvement in research. Women who are biologically capable of becoming pregnant have been customarily excluded from formal clinical trials of drugs, vaccines and medical devices owing to concern about undetermined risks to the fetus. Consequently, relatively little is known about the safety and efficacy of most drugs, vaccines or devices for such women, and this lack of knowledge can be dangerous.

A general policy of excluding from such clinical trials women biologically capable of becoming pregnant is unjust in that it deprives women as a class of persons of the benefits of the new knowledge derived from the trials. Further, it is an affront to their right of self-determination. Nevertheless, although women of childbearing age should be given the opportunity to participate in research, they should be helped to understand that the research could include risks to the fetus if they become pregnant during the research.

Although this general presumption favours the inclusion of women in research, it must be acknowledged that in some parts of the world women are vulnerable to neglect or harm in research because of their social conditioning to submit to authority, to ask no questions, and to tolerate pain and suffering. When

women in such situations are potential subjects in research, investigators need to exercise special care in the informed consent process to ensure that they have adequate time and a proper environment in which to take decisions on the basis of clearly given information.

**Individual consent of women:** In research involving women of reproductive age, whether pregnant or non-pregnant, only the informed consent of the woman herself is required for her participation. In no case should the permission of a spouse or partner replace the requirement of individual informed consent. If women wish to consult with their husbands or partners or seek voluntarily to obtain their permission before deciding to enrol in research, that is not only ethically permissible but in some contexts highly desirable. A strict requirement of authorization of spouse or partner, however, violates the substantive principle of respect for persons.

A thorough discussion of risks to the pregnant woman and to her fetus is a prerequisite for the woman's ability to make a rational decision to enrol in a clinical study. For women who are not pregnant at the outset of a study but who might become pregnant while they are still subjects, the consent discussion should include information about the alternative of voluntarily withdrawing from the study and, where legally permissible, terminating the pregnancy. Also, if the pregnancy is not terminated, they should be guaranteed a medical follow-up.

#### **Guideline 17: Pregnant women as research participants**

Pregnant women should be presumed to be eligible for participation in biomedical research. Investigators and ethical review committees should ensure that prospective subjects who are pregnant are adequately informed about the risks and benefits to themselves, their pregnancies, the fetus and their subsequent offspring, and to their fertility.

Research in this population should be performed only if it is relevant to the particular health needs of a pregnant woman or her fetus, or to the health needs of pregnant women in general, and, when appropriate, if it is supported by reliable evidence from animal experiments, particularly as to risks of teratogenicity and mutagenicity.

#### *Commentary on Guideline 17*

**The justification of research involving pregnant women** is complicated by the fact that it may present risks and potential benefits to two beings – the woman and the fetus – as well as to the person the fetus is destined to become. Though the decision about acceptability of risk should be made by the mother as part of the informed consent process, it is desirable in research directed at the health of the fetus to obtain the father's opinion also, when possible. Even when evidence concerning risks is unknown or ambiguous, the decision about acceptability of risk to the fetus should be made by the woman as part of the informed consent process.

Especially in communities or societies in which cultural beliefs accord more importance to the fetus than to the woman's life or health, women may feel

constrained to participate, or not to participate, in research. Special safeguards should be established to prevent undue inducement to pregnant women to participate in research in which interventions hold out the prospect of direct benefit to the fetus. Where fetal abnormality is not recognized as an indication for abortion, pregnant women should not be recruited for research in which there is a realistic basis for concern that fetal abnormality may occur as a consequence of participation as a subject in research.

Investigators should include in protocols on research on pregnant women a plan for monitoring the outcome of the pregnancy with regard to both the health of the woman and the short-term and long-term health of the child.

### **Guideline 18: Safeguarding confidentiality**

The investigator must establish secure safeguards of the confidentiality of subjects' research data. Subjects should be told the limits, legal or other, to the investigators' ability to safeguard confidentiality and the possible consequences of breaches of confidentiality.

#### *Commentary on Guideline 18*

**Confidentiality between investigator and subject.** Research relating to individuals and groups may involve the collection and storage of information that, if disclosed to third parties, could cause harm or distress. Investigators should arrange to protect the confidentiality of such information by, for example, omitting information that might lead to the identification of individual subjects, limiting access to the information, anonymizing data, or other means. During the process of obtaining informed consent the investigator should inform the prospective subjects about the precautions that will be taken to protect confidentiality.

Prospective subjects should be informed of limits to the ability of investigators to ensure strict confidentiality and of the foreseeable adverse social consequences of breaches of confidentiality. Some jurisdictions require the reporting to appropriate agencies of, for instance, certain communicable diseases or evidence of child abuse or neglect. Drug regulatory authorities have the right to inspect clinical-trial records, and a sponsor's clinical-compliance audit staff may require and obtain access to confidential data. These and similar limits to the ability to maintain confidentiality should be anticipated and disclosed to prospective subjects.

Participation in HIV/AIDS drug and vaccine trials may impose upon the research subjects significant associated risks of social discrimination or harm; such risks merit consideration equal to that given to adverse medical consequences of the drugs and vaccines. Efforts must be made to reduce their likelihood and severity. For example, subjects in vaccine trials must be enabled to demonstrate that their HIV seropositivity is due to their having been vaccinated rather than to natural infection. This may be accomplished by providing them with documents attesting to their participation in vaccine trials, or by maintaining a confidential register of trial subjects, from which information can be made available to outside agencies at a subject's request.

**Confidentiality between physician and patient.** Patients have the right to expect that their physicians and other health-care professionals will hold all information about them in strict confidence and disclose it only to those who need, or have a legal right to, the information, such as other attending physicians, nurses, or other health-care workers who perform tasks related to the diagnosis and treatment of patients. A treating physician should not disclose any identifying information about patients to an investigator unless each patient has given consent to such disclosure and unless an ethical review committee has approved such disclosure.

Physicians and other health-care professionals record the details of their observations and interventions in medical and other records. Epidemiological studies often make use of such records. For such studies it is usually impracticable to obtain the informed consent of each identifiable patient; an ethical review committee may waive the requirement for informed consent when this is consistent with the requirements of applicable law and provided that there are secure safeguards of confidentiality. (See also Guideline 4 Commentary: *Waiver of the consent requirement.*) In institutions in which records may be used for research purposes without the informed consent of patients, it is advisable to notify patients generally of such practices; notification is usually by means of a statement in patient-information brochures. For research limited to patients' medical records, access must be approved or cleared by an ethical review committee and must be supervised by a person who is fully aware of the confidentiality requirements.

**Issues of confidentiality in genetic research.** An investigator who proposes to perform genetic tests of known clinical or predictive value on biological samples that can be linked to an identifiable individual must obtain the informed consent of the individual or, when indicated, the permission of a legally authorized representative. Conversely, before performing a genetic test that is of known predictive value or gives reliable information about a known heritable condition, and individual consent or permission has not been obtained, investigators must see that biological samples are fully anonymized and unlinked; this ensures that no information about specific individuals can be derived from such research or passed back to them.

When biological samples are not fully anonymized and when it is anticipated that there may be valid clinical or research reasons for linking the results of genetic tests to research subjects, the investigator in seeking informed consent should assure prospective subjects that their identity will be protected by secure coding of their samples (encryption) and by restricted access to the database, and explain to them this process.

When it is clear that for medical or possibly research reasons the results of genetic tests will be reported to the subject or to the subject's physician, the subject should be informed that such disclosure will occur and that the samples to be tested will be clearly labelled.

Investigators should not disclose results of diagnostic genetic tests to relatives of subjects without the subjects' consent. In places where immediate family relatives

would usually expect to be informed of such results, the research protocol, as approved or cleared by the ethical review committee, should indicate the precautions in place to prevent such disclosure of results without the subjects' consent; such plans should be clearly explained during the process of obtaining informed consent.

**Guideline 19: Right of injured subjects to treatment and compensation**

Investigators should ensure that research subjects who suffer injury as a result of their participation are entitled to free medical treatment for such injury and to such financial or other assistance as would compensate them equitably for any resultant impairment, disability or handicap. In the case of death as a result of their participation, their dependants are entitled to compensation. Subjects must not be asked to waive the right to compensation.

*Commentary on Guideline 19*

Guideline 19 is concerned with two distinct but closely related entitlements. The first is the uncontroversial entitlement to free medical treatment and compensation for accidental injury inflicted by procedures or interventions performed exclusively to accomplish the purposes of research (non-therapeutic procedures). The second is the entitlement of dependants to material compensation for death or disability occurring as a direct result of study participation. Implementing a compensation system for research-related injuries or death is likely to be complex, however.

**Equitable compensation and free medical treatment.** Compensation is owed to research subjects who are disabled as a consequence of injury from procedures performed solely to accomplish the purposes of research. Compensation and free medical treatment are generally not owed to research subjects who suffer expected or foreseen adverse reactions to investigational therapeutic, diagnostic or preventive interventions when such reactions are not different in kind from those known to be associated with established interventions in standard medical practice. In the early stages of drug testing (Phase I and early Phase II), it is generally unreasonable to assume that an investigational drug holds out the prospect of direct benefit for the individual subject; accordingly, compensation is usually owed to individuals who become disabled as a result of serving as subjects in such studies.

The ethical review committee should determine in advance: i) the injuries for which subjects will receive free treatment and, in case of impairment, disability or handicap resulting from such injuries, be compensated; and ii) the injuries for which they will not be compensated. Prospective subjects should be informed of the committee's decisions, as part of the process of informed consent. As an ethical review committee cannot make such advance determination in respect of unexpected or unforeseen adverse reactions, such reactions must be presumed compensable and should be reported to the committee for prompt review as they occur.

Subjects must not be asked to waive their rights to compensation or required to show negligence or lack of a reasonable degree of skill on the part of the investigator in order to claim free medical treatment or compensation. The informed consent process or form should contain no words that would absolve an investigator from responsibility in the case of accidental injury, or that would imply that subjects would waive their right to seek compensation for impairment, disability or handicap. Prospective subjects should be informed that they will not need to take legal action to secure the free medical treatment or compensation for injury to which they may be entitled. They should also be told what medical service or organization or individual will provide the medical treatment and what organization will be responsible for providing compensation.

**Obligation of the sponsor with regard to compensation.** Before the research begins, the sponsor, whether a pharmaceutical company or other organization or institution, or a government (where government insurance is not precluded by law), should agree to provide compensation for any physical injury for which subjects are entitled to compensation, or come to an agreement with the investigator concerning the circumstances in which the investigator must rely on his or her own insurance coverage (for example, for negligence or failure of the investigator to follow the protocol, or where government insurance coverage is limited to negligence). In certain circumstances it may be advisable to follow both courses. Sponsors should seek adequate insurance against risks to cover compensation, independent of proof of fault.

#### **Guideline 20: Strengthening capacity for ethical and scientific review and biomedical research**

Many countries lack the capacity to assess or ensure the scientific quality or ethical acceptability of biomedical research proposed or carried out in their jurisdictions. In externally sponsored collaborative research, sponsors and investigators have an ethical obligation to ensure that biomedical research projects for which they are responsible in such countries contribute effectively to national or local capacity to design and conduct biomedical research, and to provide scientific and ethical review and monitoring of such research.

Capacity-building may include, but is not limited to, the following activities:

- establishing and strengthening independent and competent ethical review processes/ committees;
- strengthening research capacity;
- developing technologies appropriate to health-care and biomedical research training of research and health-care staff;
- educating the community from which research subjects will be drawn.

#### *Commentary on Guideline 20*

External sponsors and investigators have an ethical obligation to contribute to a host country's sustainable capacity for independent scientific and ethical review

and biomedical research. Before undertaking research in a host country with little or no such capacity, external sponsors and investigators should include in the research protocol a plan that specifies the contribution they will make. The amount of capacity building reasonably expected should be proportional to the magnitude of the research project. A brief epidemiological study involving only review of medical records, for example, would entail relatively little, if any, such development, whereas a considerable contribution is to be expected of an external sponsor of, for instance, a large-scale vaccine field-trial expected to last two or three years.

The specific capacity-building objectives should be determined and achieved through dialogue and negotiation between external sponsors and host-country authorities. External sponsors would be expected to employ and, if necessary, train local individuals to function as investigators, research assistants or data managers, for example, and to provide, as necessary, reasonable amounts of financial, educational and other assistance for capacity-building. To avoid conflict of interest and safeguard the independence of review committees, financial assistance should not be provided directly to them; rather, funds should be made available to appropriate authorities in the host-country government or to the host research institution.

(See also Guideline 10: *Research in populations and communities with limited resources*)

**Guideline 21: Ethical obligation of external sponsors to provide health-care services**

External sponsors are ethically obliged to ensure the availability of:

- health-care services that are essential to the safe conduct of the research;
- treatment for subjects who suffer injury as a consequence of research interventions; and,
- services that are a necessary part of the commitment of a sponsor to make a beneficial intervention or product developed as a result of the research reasonably available to the population or community concerned.

*Commentary on Guideline 21*

Obligations of external sponsors to provide health-care services will vary with the circumstances of particular studies and the needs of host countries. The sponsors' obligations in particular studies should be clarified before the research is begun. The research protocol should specify what health-care services will be made available, during and after the research, to the subjects themselves, to the community from which the subjects are drawn, or to the host country, and for how long. The details of these arrangements should be agreed by the sponsor, officials of the host country, other interested parties, and, when appropriate, the community from which subjects are to be drawn. The agreed arrangements should be specified in the consent process and document.

Although sponsors are, in general, not obliged to provide health-care services beyond that which is necessary for the conduct of the research, it is morally praiseworthy to do so. Such services typically include treatment for diseases contracted in the course of the study. It might, for example, be agreed to treat cases of an infectious disease contracted during a trial of a vaccine designed to provide immunity to that disease, or to provide treatment of incidental conditions unrelated to the study.

The obligation to ensure that subjects who suffer injury as a consequence of research interventions obtain medical treatment free of charge, and that compensation be provided for death or disability occurring as a consequence of such injury, is the subject of Guideline 19, on the scope and limits of such obligations.

When prospective or actual subjects are found to have diseases unrelated to the research, or cannot be enrolled in a study because they do not meet the health criteria, investigators should, as appropriate, advise them to obtain, or refer them for, medical care. In general, also, in the course of a study, sponsors should disclose to the proper health authorities information of public health concern arising from the research.

The obligation of the sponsor to make reasonably available for the benefit of the population or community concerned any intervention or product developed, or knowledge generated, as a result of the research is considered in Guideline 10: *Research in populations and communities with limited resources*.

Available online at: [http://www.cioms.ch/frame\\_guidelines\\_nov\\_2002.htm](http://www.cioms.ch/frame_guidelines_nov_2002.htm)

## UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS (UNESCO, 2005)

### THE GENERAL CONFERENCE,

Conscious of the unique capacity of human beings to reflect upon their own existence and on their environment, to perceive injustice, to avoid danger, to assume responsibility, to seek cooperation and to exhibit the moral sense that gives expression to ethical principles,

**Reflecting** on the rapid developments in science and technology, which increasingly affect our understanding of life and life itself, resulting in a strong demand for a global response to the ethical implications of such developments,

**Recognizing** that ethical issues raised by the rapid advances in science and their technological applications should be examined with due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

**Resolving** that it is necessary and timely for the international community to state universal principles that will provide a foundation for humanity's response to the ever-increasing dilemmas and controversies that science and technology present for humankind and for the environment,

**Recalling** the Universal Declaration of Human Rights of 10 December 1948, the Universal Declaration on the Human Genome and Human Rights adopted by the General Conference of UNESCO on 11 November 1997 and the International Declaration on Human Genetic Data adopted by the General Conference of UNESCO on 16 October 2003,

**Noting** the United Nations International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights of 16 December 1966, the United Nations International Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the United Nations Convention on the Elimination of All Forms of Discrimination against Women of 18 December 1979, the United Nations Convention on the Rights of the Child of 20 November 1989, the United Nations Convention on Biological Diversity of 5 June 1992, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities adopted by the General Assembly of the United Nations in 1993, the UNESCO Recommendation on the Status of Scientific Researchers of 20 November 1974, the UNESCO Declaration on Race and Racial Prejudice of 27 November 1978, the UNESCO Declaration on the Responsibilities of the Present Generations Towards Future Generations of 12 November 1997, the UNESCO Universal Declaration on Cultural Diversity of 2 November 2001, the ILO Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries of 27 June 1989, the International Treaty on Plant Genetic Resources for Food and Agriculture which was adopted by the FAO Conference on 3 November 2001 and entered into force on 29 June 2004, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) annexed to the Marrakech Agreement establishing the World Trade Organization, which entered into force on 1 January 1995, the Doha Declaration on the TRIPS Agreement and Public Health of 14 November 2001 and other relevant international instruments adopted by the United Nations and the specialized agencies of the United Nations system, in particular the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO),

**Also noting** international and regional instruments in the field of bioethics, including the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine of the Council of Europe, which was adopted in 1997 and entered into force in 1999, together with its Additional Protocols, as well as national legislation and regulations in the field of bioethics and the international and regional codes of conduct and guidelines and other texts in the field of bioethics, such as the Declaration of Helsinki of the World Medical Association on Ethical Principles for Medical Research Involving Human Subjects, adopted in 1964 and amended in 1975, 1983, 1989, 1996 and 2000 and the International Ethical Guidelines for Biomedical Research Involving Human Subjects of the Council for International Organizations of Medical Sciences, adopted in 1982 and amended in 1993 and 2002,

**Recognizing** that this Declaration is to be understood in a manner consistent with domestic and international law in conformity with human rights law,

**Recalling** the Constitution of UNESCO adopted on 16 November 1945,

**Considering** UNESCO's role in identifying universal principles based on shared ethical values to guide scientific and technological development and social transformation in order to identify emerging challenges in science and technology taking into account the responsibility of the present generations towards future generations, and that questions of bioethics, which necessarily have an international dimension, should be treated as a whole, drawing on the principles already stated in the Universal Declaration on the Human Genome and Human Rights and the International Declaration on Human Genetic Data and taking account not only of the current scientific context but also of future developments,

**Aware** that human beings are an integral part of the biosphere, with an important role in protecting one another and other forms of life, in particular animals,

**Recognizing** that, based on the freedom of science and research, scientific and technological developments have been, and can be, of great benefit to humankind in increasing, *inter alia*, life expectancy and improving the quality of life, and emphasizing that such developments should always seek to promote the welfare of individuals, families, groups or communities and humankind as a whole in the recognition of the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

**Recognizing** that health does not depend solely on scientific and technological research developments but also on psychosocial and cultural factors,

**Also recognizing** that decisions regarding ethical issues in medicine, life sciences and associated technologies may have an impact on individuals, families, groups or communities and humankind as a whole,

**Bearing in mind** that cultural diversity, as a source of exchange, innovation and creativity, is necessary to humankind and, in this sense, is the common heritage of humanity, but emphasizing that it may not be invoked at the expense of human rights and fundamental freedoms,

**Also bearing in mind** that a person's identity includes biological, psychological, social, cultural and spiritual dimensions,

**Recognizing** that unethical scientific and technological conduct has had a particular impact on indigenous and local communities,

**Convinced** that moral sensitivity and ethical reflection should be an integral part of the process of scientific and technological developments and that bioethics should play a predominant role in the choices that need to be made concerning issues arising from such developments,

**Considering** the desirability of developing new approaches to social responsibility to ensure that progress in science and technology contributes to justice, equity and to the interest of humanity,

**Recognizing** that an important way to evaluate social realities and achieve equity is to pay attention to the position of women,

**Stressing** the need to reinforce international cooperation in the field of bioethics, taking into account, in particular, the special needs of developing countries, indigenous communities and vulnerable populations,

**Considering** that all human beings, without distinction, should benefit from the same high ethical standards in medicine and life science research,

**Proclaims** the principles that follow and adopts the present Declaration.

## GENERAL PROVISIONS

### Article 1 – Scope

1. This Declaration addresses ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions.

2. This Declaration is addressed to States. As appropriate and relevant, it also provides guidance to decisions or practices of individuals, groups, communities, institutions and corporations, public and private.

### Article 2 – Aims

The aims of this Declaration are:

- a. to provide a universal framework of principles and procedures to guide States in the formulation of their legislation, policies or other instruments in the field of bioethics;
- b. to guide the actions of individuals, groups, communities, institutions and corporations, public and private;
- c. to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law;
- d. to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms;
- e. to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole;
- f. to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries;
- g. to safeguard and promote the interests of the present and future generations;
- h. to underline the importance of biodiversity and its conservation as a common concern of humankind.

## **PRINCIPLES**

Within the scope of this Declaration, in decisions or practices taken or carried out by those to whom it is addressed, the following principles are to be respected.

### **Article 3 – Human dignity and human rights**

1. Human dignity, human rights and fundamental freedoms are to be fully respected.
2. The interests and welfare of the individual should have priority over the sole interest of science or society.

### **Article 4 – Benefit and harm**

In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

### **Article 5 – Autonomy and individual responsibility**

The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

### **Article 6 – Consent**

Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned. The information should be adequate, provided in a comprehensible form and should include modalities for withdrawal of consent. Consent may be withdrawn by the person concerned at any time and for any reason without any disadvantage or prejudice. Exceptions to this principle should be made only in accordance with ethical and legal standards adopted by States, consistent with the principles and provisions set out in this Declaration, in particular in Article 27, and international human rights law.

In appropriate cases of research carried out on a group of persons or a community, additional agreement of the legal representatives of the group or community concerned may be sought. In no case should a collective community agreement or the consent of a community leader or other authority substitute for an individual's informed consent.

### **Article 7 – Persons without the capacity to consent**

In accordance with domestic law, special protection is to be given to persons who do not have the capacity to consent:

- a. Authorization for research and medical practice should be obtained in accordance with the best interest of the person concerned and in accordance with domestic law. However, the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent;
- b. Research should only be carried out for his or her direct health benefit, subject to the authorization and the protective conditions prescribed by law, and if there is no research alternative of comparable effectiveness with research participants able to consent. Research which does not have potential direct health benefit should only be undertaken by way of exception, with the utmost restraint, exposing the person only to a minimal risk and minimal burden and, if the research is expected to contribute to the health benefit of other persons in the same category, subject to the conditions prescribed by law and compatible with the protection of the individual's human rights. Refusal of such persons to take part in research should be respected.

#### **Article 8 – Respect for human vulnerability and personal integrity**

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

#### **Article 9 – Privacy and confidentiality**

The privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law.

#### **Article 10 – Equality, justice and equity**

The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

#### **Article 11 – Non-discrimination and non-stigmatization**

No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.

#### **Article 12 – Respect for cultural diversity and pluralism**

The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope.

**Article 13 – Solidarity and cooperation**

Solidarity among human beings and international cooperation towards that end are to be encouraged.

**Article 14 – Social responsibility and health**

1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.
2. Taking into account 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, progress in science and technology should advance:
  - a. access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;
  - b. access to adequate nutrition and water;
  - c. improvement of living conditions and the environment;
  - d. elimination of the marginalization and the exclusion of persons on the basis of any grounds;
  - e. reduction of poverty and illiteracy.

**Article 15 – Sharing of benefits**

1. Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms:
  - a. special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research;
  - b. access to quality health care;
  - c. provision of new diagnostic and therapeutic modalities or products stemming from research;
  - d. support for health services;
  - e. access to scientific and technological knowledge;
  - f. capacity-building facilities for research purposes;
  - g. other forms of benefit consistent with the principles set out in this Declaration.
2. Benefits should not constitute improper inducements to participate in research.

**Article 16 – Protecting future generations**

The impact of life sciences on future generations, including on their genetic constitution, should be given due regard.

**Article 17 – Protection of the environment, the biosphere and biodiversity**

Due regard is to be given to the interconnection between human beings and other

forms of life, to the importance of appropriate access and utilization of biological and genetic resources, to respect for traditional knowledge and to the role of human beings in the protection of the environment, the biosphere and biodiversity.

## **APPLICATION OF THE PRINCIPLES**

### **Article 18 – Decision-making and addressing bioethical issues**

1. Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavor should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues.
2. Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis.
3. Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.

### **Article 19 – Ethics committees**

1. Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to:
  2. assess the relevant ethical, legal, scientific and social issues related to research projects involving human beings;
  3. provide advice on ethical problems in clinical settings; assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this Declaration;
  4. foster debate, education and public awareness of, and engagement in, bioethics.

### **Article 20 – Risk assessment and management**

Appropriate assessment and adequate management of risk related to medicine, life sciences and associated technologies should be promoted.

### **Article 21 – Transnational practices**

1. States, public and private institutions, and professionals associated with transnational activities should endeavor to ensure that any activity within the scope of this Declaration, undertaken, funded or otherwise pursued in whole or in part in different States, is consistent with the principles set out in this Declaration.
2. When research is undertaken or otherwise pursued in one or more States (the host State(s)) and funded by a source in another State, such research should be the object of an appropriate level of ethical review in the host State(s) and the State in which the funder is located. This review should be based on ethical and legal standards that are consistent with the principles set out in this Declaration.
3. Transnational health research should be responsive to the needs of host countries, and the importance of research contributing to the alleviation of urgent global health problems should be recognized.

4. When negotiating a research agreement, terms for collaboration and agreement on the benefits of research should be established with equal participation by those party to the negotiation.

5. States should take appropriate measures, both at the national and international levels, to combat bioterrorism and illicit traffic in organs, tissues, samples, genetic resources and genetic-related materials.

## **PROMOTION OF THE DECLARATION**

### **Article 22 – Role of States**

1. States should take all appropriate measures, whether of a legislative, administrative or other character, to give effect to the principles set out in this Declaration in accordance with international human rights law. Such measures should be supported by action in the spheres of education, training and public information

2. States should encourage the establishment of independent, multidisciplinary and pluralist ethics committees, as set out in Article 19.

### **Article 23 – Bioethics education, training and information**

1. In order to promote the principles set out in this Declaration and to achieve a better understanding of the ethical implications of scientific and technological developments, in particular for young people, States should endeavour to foster bioethics education and training at all levels as well as to encourage information and knowledge dissemination programmes about bioethics.

2. States should encourage the participation of international and regional intergovernmental organizations and international, regional and national non-governmental organizations in this endeavor.

### **Article 24 – International cooperation**

1. States should foster international dissemination of scientific information and encourage the free flow and sharing of scientific and technological knowledge.

2. *Within the framework of international cooperation, States should promote cultural and scientific cooperation and enter into bilateral and multilateral agreements enabling developing countries to build up their capacity to participate in generating and sharing scientific knowledge, the related know-how and the benefits thereof.*

3. States should respect and promote solidarity between and among States, as well as individuals, families, groups and communities, with special regard for those rendered vulnerable by disease or disability or other personal, societal or environmental conditions and those with the most limited resources.

### **Article 25 – Follow-up action by UNESCO**

1. UNESCO shall promote and disseminate the principles set out in this Declaration. In doing so, UNESCO should seek the help and assistance of the Intergovernmental Bioethics Committee (IGBC) and the International Bioethics Committee (IBC).

2. UNESCO shall reaffirm its commitment to dealing with bioethics and to promoting collaboration between IGBC and IBC.

### **FINAL PROVISIONS**

#### **Article 26 – Interrelation and complementarity of the principles**

This Declaration is to be understood as a whole and the principles are to be understood as complementary and interrelated. Each principle is to be considered in the context of the other principles, as appropriate and relevant in the circumstances.

#### **Article 27 – Limitations on the application of the principles**

If the application of the principles of this Declaration is to be limited, it should be by law, including laws in the interests of public safety, for the investigation, detection and prosecution of criminal offences, for the protection of public health or for the protection of the rights and freedoms of others. Any such law needs to be consistent with international human rights law.

#### **Article 28 – Denial of acts contrary to human rights, fundamental freedoms and human dignity**

Nothing in this Declaration may be interpreted as implying for any State, group or person any claim to engage in any activity or to perform any act contrary to human rights, fundamental freedoms and human dignity.

Available online at: [http://portal.unesco.org/en/ev.php-URL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html)

## 4/CHILDREN

- Convention on the Rights of the Child (United Nations, 1990)
- General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (United Nations, 2003)

### CONVENTION ON THE RIGHTS OF THE CHILD

*(United Nations, 1990)*

#### PREAMBLE

##### **The States Parties to the present Convention,**

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

**Bearing** in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

**Recognizing** that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

**Recalling** that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

**Convinced** that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

**Recognizing** that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

**Considering** that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

**Bearing in mind** that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration

of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

**Bearing in mind that**, as indicated in the Declaration of the Rights of the Child, “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth”,

**Recalling** the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

**Taking due account** of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child,

**Recognizing** the importance of international cooperation for improving the living conditions of children in every country, in particular in the developing countries, Have agreed as follows:

## **PART I**

### **Article 1**

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

### **Article 2**

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child’s parents, legal guardians, or family members.

### **Article 3**

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform to the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

#### **Article 4**

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

#### **Article 5**

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

#### **Article 6**

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

#### **Article 7**

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

#### **Article 8**

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

**Article 9**

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.
2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.
4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

**Article 10**

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.
2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances, personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (*ordre public*), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

**Article 11**

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.
2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

**Article 12**

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

**Article 13**

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
  - a. For respect of the rights or reputations of others; or
  - b. For the protection of national security or of public order (*ordre public*), or of public health or morals.

**Article 14**

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.
2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

**Article 15**

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.
2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic

society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others.

#### **Article 16**

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home, or correspondence, nor to unlawful attacks on his or her honour and reputation.
2. The child has the right to the protection of the law against such interference or attacks.

#### **Article 17**

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:

- a. Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;
- b. Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;
- c. Encourage the production and dissemination of children's books;
- d. Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;
- e. Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

#### **Article 18**

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

### Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

### Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, *inter alia*, foster placement, *kafalah* of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

### Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

- a. Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;
- b. Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;
- c. Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;
- d. Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

- e. Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

## **Article 22**

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.
2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or nongovernmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.

## **Article 23**

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.
3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.
4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including

dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

#### **Article 24**

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
  - a. To diminish infant and child mortality;
  - b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
  - c. To combat disease and malnutrition, including within the framework of primary health care, through *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
  - d. To ensure appropriate pre-natal and post-natal health care for mothers;
  - e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
  - f. To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

#### **Article 25**

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

#### **Article 26**

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

#### **Article 27**

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.
3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.
4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

#### **Article 28**

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
  - a. Make primary education compulsory and available free to all;
  - b. Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
  - c. Make higher education accessible to all on the basis of capacity by every appropriate means;
  - d. Make educational and vocational information and guidance available and accessible to all children;
  - e. Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.
3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the

elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

### **Article 29**

1. States Parties agree that the education of the child shall be directed to:
  - a. The development of the child's personality, talents and mental and physical abilities to their fullest potential;
  - b. The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
  - c. The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;
  - d. The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;
  - e. The development of respect for the natural environment.
2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

### **Article 30**

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

### **Article 31**

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

### **Article 32**

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to

interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

**2.** States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

- a.** Provide for a minimum age or minimum ages for admission to employment;
- b.** Provide for appropriate regulation of the hours and conditions of employment;
- c.** Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

### **Article 33**

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

### **Article 34**

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- a.** The inducement or coercion of a child to engage in any unlawful sexual activity;
- b.** The exploitative use of children in prostitution or other unlawful sexual practices;
- c.** The exploitative use of children in pornographic performances and materials.

### **Article 35**

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

### **Article 36**

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

### **Article 37**

States Parties shall ensure that:

- a.** No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life

imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

**b.** No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

**c.** Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

**d.** Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

#### **Article 38**

**1.** States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

**2.** States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

**3.** States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

**4.** In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

#### **Article 39**

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

#### **Article 40**

**1.** States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent

with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

**2.** To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:

- a.** No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;
- b.** Every child alleged as or accused of having infringed the penal law has at least the following guarantees:
  - i.** To be presumed innocent until proven guilty according to law;
  - ii.** To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;
  - iii.** To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;
  - iv.** Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;
  - v.** If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;
  - vi.** To have the free assistance of an interpreter if the child cannot understand or speak the language used;
  - vii.** To have his or her privacy fully respected at all stages of the proceedings.

**3.** States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

- a.** The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;
- b.** Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected.

4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

#### **Article 41**

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

- a. The law of a State party; or
- b. International law in force for that State.

### **PART II**

#### **Article 42**

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

#### **Article 43**

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if re-nominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.
7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.
8. The Committee shall establish its own rules of procedure.
9. The Committee shall elect its officers for a period of two years.
10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.
11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.
12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

#### **Article 44**

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights
  - a. Within two years of the entry into force of the Convention for the State Party concerned;
  - b. Thereafter every five years.
2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.
3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.
4. The Committee may request from States Parties further information relevant to the implementation of the Convention.
5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

#### **Article 45**

In order to foster the effective implementation of the Convention and to encourage international cooperation in the field covered by the Convention:

- a. The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;
- b. The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;
- c. The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;
- d. The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

### **PART III**

#### **Article 46**

The present Convention shall be open for signature by all States.

#### **Article 47**

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

#### **Article 48**

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

**Article 49**

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.
2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

**Article 50**

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.
2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.
3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

**Article 51**

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.
2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.
3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General.

**Article 52**

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

**Article 53**

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

**Article 54**

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

Available online at: <http://www.unhcr.ch/html/menu3/b/k2crc.htm>

## GENERAL COMMENT NO. 4 ADOLESCENT HEALTH AND DEVELOPMENT IN THE CONTEXT OF THE CONVENTION ON THE RIGHTS OF THE CHILD

*(United Nations, 2003)*

**INTRODUCTION**

1. The Convention on the Rights of the Child defines a child as “every human being below the age of 18 years unless, under the law applicable, majority is attained earlier” (art. 1). Consequently, adolescents up to 18 years old are holders of all the rights enshrined in the Convention; they are entitled to special protection measures and, according to their evolving capacities, they can progressively exercise their rights (art. 5).
2. Adolescence is a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviours and roles involving new responsibilities requiring new knowledge and skills. While adolescents are in general a healthy population group, adolescence also poses new challenges to health and development owing to their relative vulnerability and pressure from society, including peers, to adopt risky health behaviour. These challenges include developing an individual identity and dealing with one’s sexuality. The dynamic transition period to adulthood is also generally a period of positive changes, prompted by the significant capacity of adolescents to learn rapidly, to experience new and diverse situations, to develop and use critical thinking, to familiarize themselves with freedom, to be creative and to socialize.
3. The Committee on the Rights of the Child notes with concern that in implementing their obligations under the Convention, States parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development. This has motivated the Committee to adopt the present general comment in order to raise awareness and provide States parties with guidance and support in their efforts to guarantee the respect for, protection and fulfilment of the rights of adolescents, including through the formulation of specific strategies and policies.
4. The Committee understands the concepts of “health and development” more

broadly than being strictly limited to the provisions defined in articles 6 (right to life, survival and development) and 24 (right to health) of the Convention. One of the aims of this general comment is precisely to identify the main human rights that need to be promoted and protected in order to ensure that adolescents do enjoy the highest attainable standard of health, develop in a well-balanced manner, and are adequately prepared to enter adulthood and assume a constructive role in their communities and in society at large. This general comment should be read in conjunction with the Convention and its two Optional Protocols on the sale of children, child prostitution and child pornography, and on the involvement of children in armed conflict, as well as other relevant international human rights norms and standards.[1]

## **I. FUNDAMENTAL PRINCIPLES AND OTHER OBLIGATIONS OF STATES PARTIES**

5. As recognized by the World Conference on Human Rights (1993) and repeatedly stated by the Committee, children's rights too are indivisible and interrelated. In addition to articles 6 and 24, other provisions and principles of the Convention are crucial in guaranteeing that adolescents fully enjoy their right to health and development.

### **The right to non-discrimination**

6. States parties have the obligation to ensure that all human beings below 18 enjoy all the rights set forth in the Convention without discrimination (art. 2), including with regard to "race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status". These grounds also cover adolescents' sexual orientation and health status (including HIV/AIDS and mental health). Adolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.

### **Appropriate guidance in the exercise of rights**

7. The Convention acknowledges the responsibilities, rights and duties of parents (or other persons legally responsible for the child) "to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention" (art. 5). The Committee believes that parents or other persons legally responsible for the child need to fulfil with care their right and responsibility to provide direction and guidance to their adolescent children in the exercise by the latter of their rights. They have an obligation to take into account the adolescents' views, in accordance with their age and maturity, and to provide a safe and supportive environment in which the adolescent can develop. Adolescents need to be recognized by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction.

### **Respect for the views of the child**

**8.** The right to express views freely and have them duly taken into account (art. 12) is also fundamental in realizing adolescents' right to health and development. States parties need to ensure that adolescents are given a genuine chance to express their views freely on all matters affecting them, especially within the family, in school, and in their communities. In order for adolescents to be able safely and properly to exercise this right, public authorities, parents and other adults working with or for children need to create an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents' participating equally including in decision-making processes.

### **Legal and judicial measures and processes**

**9.** Under article 4 of the Convention, "States parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognized" therein. In the context of the rights of adolescents to health and development, States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be the same for boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (arts. 5 and 12 to 17). Further, adolescents need to have easy access to individual complaint systems as well as judicial and appropriate non-judicial redress mechanisms that guarantee fair and due process, with special attention to the right to privacy (art. 16).

### **Civil rights and freedoms**

**10.** The Convention defines the civil rights and freedoms of children and adolescents in its articles 13 to 17. These are fundamental in guaranteeing the right to health and development of adolescents. Article 17 states that the child has the right to "access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health". The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.

**11.** In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning

adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.

### **Protection from all forms of abuse, neglect, violence and exploitation [2]**

**12.** States parties must take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation (arts. 19, 32-36 and 38), paying increased attention to the specific forms of abuse, neglect, violence and exploitation that affects this age group. In particular, they should adopt special measures to ensure the physical, sexual and mental integrity of adolescents with disabilities, who are particularly vulnerable to abuse and neglect. States parties should also ensure that adolescents affected by poverty who are socially marginalized are not criminalized. In this regard, financial and human resources need to be allocated to promote research that would inform the adoption of effective local and national laws, policies and programmes. Policies and strategies should be reviewed regularly and revised accordingly. In taking these measures, States parties have to take into account the evolving capacities of adolescents and involve them in an appropriate manner in developing measures, including programmes, designed to protect them. In this context, the Committee emphasizes the positive impact that peer education can have, and the positive influence of proper role models, especially those in the worlds of arts, entertainment and sports.

### **Data collection**

**13.** Systematic data collection is necessary for States parties to be able to monitor the health and development of adolescents. States parties should adopt data-collection mechanisms that allow desegregation by sex, age, origin and socio-economic status so that the situation of different groups can be followed. Data should also be collected to study the situation of specific groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, working adolescents, etc. Where appropriate, adolescents should participate in the analysis to ensure that the information is understood and utilized in an adolescent-sensitive way.

## **II. CREATING A SAFE AND SUPPORTIVE ENVIRONMENT**

**14.** The health and development of adolescents are strongly determined by the environments in which they live. Creating a safe and supportive environment entails addressing attitudes and actions of both the immediate environment of the adolescent – family, peers, schools and services – as well as the wider environment created by, *inter alia*, community and religious leaders, the media, national and local policies and legislation. The promotion and enforcement of the provisions and principles of the Convention, especially articles 2-6, 12-17, 24, 28, 29 and 31, are

key to guaranteeing adolescents' right to health and development. States parties should take measures to raise awareness and stimulate and/or regulate action through the formulation of policy or the adoption of legislation and the implementation of programmes specifically for adolescents.

**15.** The Committee stresses the importance of the family environment, including the members of the extended family and community or other persons legally responsible for the child or adolescent (arts. 5 and 18). While most adolescents grow up in well-functioning family environments, for some the family does not constitute a safe and supportive milieu.

**16.** The Committee calls upon States parties to develop and implement, in a manner consistent with adolescents' evolving capacities, legislation, policies and programmes to promote the health and development of adolescents by (a) providing parents (or legal guardians) with appropriate assistance through the development of institutions, facilities and services that adequately support the well-being of adolescents, including, when needed, the provision of material assistance and support with regard to nutrition, clothing and housing (art. 27 (3)); (b) providing adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behaviour and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent's rights (art. 27 (3)); (c) providing adolescent mothers and fathers with support and guidance for both their own and their children's well-being (art. 24 (f), 27 (2-3)); (d) giving, while respecting the values and norms of ethnic and other minorities, special attention, guidance and support to adolescents and parents (or legal guardians), whose traditions and norms may differ from those in the society where they live; and (e) ensuring that interventions in the family to protect the adolescent and, when necessary, separate her/him from the family, e.g. in case of abuse or neglect, are in accordance with applicable laws and procedures. Such laws and procedures should be reviewed to ensure that they conform to the principles of the Convention.

**17.** The school plays an important role in the life of many adolescents, as the venue for learning, development and socialization. Article 29 (1) states that education must be directed to "the development of the child's personality, talents and mental and physical abilities to their fullest potential". In addition, general comment No. 1 on the aims of education states that "*Education must also be aimed at ensuring that ... no child leaves school without being equipped to face the challenges that he or she can expect to be confronted with in life. Basic skills should include ... the ability to make well-balanced decisions; to resolve conflicts in a non-violent manner; and to develop a healthy lifestyle [and] good social relationships ...*". Considering the importance of appropriate education for the current and future health and development of adolescents, as well as for their children, the Committee urges States parties, in line with articles 28 and 29 of the Convention to (a) ensure that quality primary education is compulsory and available, accessible and free to all and that secondary and higher education are available and accessible to all

adolescents; (b) provide well-functioning school and recreational facilities which do not pose health risks to students, including water and sanitation and safe journeys to school; (c) take the necessary actions to prevent and prohibit all forms of violence and abuse, including sexual abuse, corporal punishment and other inhuman, degrading or humiliating treatment or punishment in school, by school personnel as well as among students; (d) initiate and support measures, attitudes and activities that promote healthy behaviour by including relevant topics in school curricula.

**18.** During adolescence, an increasing number of young people are leaving school to start working to help support their families or for wages in the formal or informal sector. Participation in work activities in accordance with international standards, as long as it does not jeopardize the enjoyment of any of the other rights of adolescents, including health and education, may be beneficial for the development of the adolescent. The Committee urges States parties to take all necessary measures to abolish all forms of child labour, starting with the worst forms, to continuously review national regulations on minimum ages for employment with a view to making them compatible with international standards, and to regulate the working environment and conditions for adolescents who are working (in accordance with article 32 of the Convention, as well as ILO Conventions Nos. 138 and 182), so as to ensure that they are fully protected and have access to legal redress mechanisms.

**19.** The Committee also stresses that in accordance with article 23 (3) of the Convention, the special rights of adolescents with disabilities should be taken into account and assistance provided to ensure that the disabled child/adolescent has effective access to and receives good quality education. States should recognize the principle of equal primary, secondary and tertiary educational opportunities for disabled children/adolescents, where possible in regular schools.

**20.** The Committee is concerned that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties. There are also non-health-related concerns: children who marry, especially girls, are often obliged to leave the education system and are marginalized from social activities. Further, in some States parties married children are legally considered adults, even if they are under 18, depriving them of all the special protection measures they are entitled under the Convention. The Committee strongly recommends that States parties review and, where necessary, reform their legislation and practice to increase the minimum age for marriage with and without parental consent to 18 years, for both girls and boys. The Committee on the Elimination of Discrimination against Women has made a similar recommendation (general comment No. 21 of 1994).

**21.** In most countries accidental injuries or injuries due to violence are a leading cause of death or permanent disability among adolescents. In that respect, the Committee is concerned about the injuries and death resulting from road traffic accidents, which affect adolescents disproportionately. States parties should adopt and enforce legislation and programmes to improve road safety, including driving

education for and examination of adolescents and the adoption or strengthening of legislation known to be highly effective such as the obligations to have a valid driver's licence, wear seat belts and crash helmets, and the designation of pedestrian areas.

**22.** The Committee is also very concerned about the high rate of suicide among this age group. Mental disorders and psychosocial illness are relatively common among adolescents. In many countries symptoms such as depression, eating disorders and self-destructive behaviours, sometimes leading to self-inflicted injuries and suicide, are increasing. They may be related to, *inter alia*, violence, ill-treatment, abuse and neglect, including sexual abuse, unrealistically high expectations, and/or bullying or hazing in and outside school. States parties should provide these adolescents with all the necessary services.

**23.** Violence results from a complex interplay of individual, family, community and societal factors. Vulnerable adolescents such as those who are homeless or who are living in institutions, who belong to gangs or who have been recruited as child soldiers are especially exposed to both institutional and interpersonal violence. Under article 19 of the Convention, States parties must take all appropriate measures<sup>[3]</sup> to prevent and eliminate: (a) institutional violence against adolescents, including through legislation and administrative measures in relation to public and private institutions for adolescents (schools, institutions for disabled adolescents, juvenile reformatories, etc.), and training and monitoring of personnel in charge of institutionalized children or who otherwise have contact with children through their work, including the police; and (b) interpersonal violence among adolescents, including by supporting adequate parenting and opportunities for social and educational development in early childhood, fostering non-violent cultural norms and values (as foreseen in article 29 of the Convention), strictly controlling firearms and restricting access to alcohol and drugs.

**24.** In light of articles 3, 6, 12, 19 and 24 (3) of the Convention, States parties should take all effective measures to eliminate all acts and activities which threaten the right to life of adolescents, including honour killings. The Committee strongly urges States parties to develop and implement awareness-raising campaigns, education programmes and legislation aimed at changing prevailing attitudes, and address gender roles and stereotypes that contribute to harmful traditional practices. Further, States parties should facilitate the establishment of multidisciplinary information and advice centres regarding the harmful aspects of some traditional practices, including early marriage and female genital mutilation.

**25.** The Committee is concerned about the influence exerted on adolescent health behaviours by the marketing of unhealthy products and lifestyles. In line with article 17 of the Convention, States parties are urged to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources. States parties are therefore urged to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents.<sup>[4]</sup>

### III. INFORMATION, SKILLS DEVELOPMENT, COUNSELLING, AND HEALTH SERVICES

**26.** Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity.

**27.** In order to act adequately on the information, adolescents need to develop the skills necessary, including self-care skills, such as how to plan and prepare nutritionally balanced meals and proper personal hygiene habits, and skills for dealing with particular social situations such as interpersonal communication, decision-making, and coping with stress and conflict. States parties should stimulate and support opportunities to build such skills through, *inter alia*, formal and informal education and training programmes, youth organizations and the media.

**28.** In light of articles 3, 17 and 24 of the Convention, States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys. To this end, States parties are encouraged to ensure that adolescents are actively involved in the design and dissemination of information through a variety of channels beyond the school, including youth organizations, religious, community and other groups and the media.

**29.** Under article 24 of the Convention, States parties are urged to provide adequate treatment and rehabilitation for adolescents with mental disorders, to make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress. States parties are also urged to combat discrimination and stigma surrounding mental disorders, in line with their obligations under article 2. Every adolescent with a mental disorder has the right to be treated and cared for, as far as possible, in the community in which he or she lives. Where hospitalization or placement in a psychiatric institution is necessary, this decision should be made in accordance with the principle of the best interests of the child. In the event of hospitalization or institutionalization, the patient should be given the maximum possible opportunity to enjoy all his or her rights as recognized under the Convention, including the rights to education and to have access to recreational activities.[5] Where appropriate, adolescents should be separated from adults.

States parties must ensure that adolescents have access to a personal representative other than a family member to represent their interests, when necessary and appropriate.[6] In accordance with article 25 of the Convention, States parties should undertake periodic review of the placement of adolescents in hospitals or psychiatric institutions.

**30.** Adolescents, both girls and boys, are at risk of being infected with and affected by STDs, including HIV/AIDS.[7] States should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible. To this end, States parties are urged (a) to develop effective prevention programmes, including measures aimed at changing cultural views about adolescents' need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality; (b) to adopt legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalization of adolescents who are already infected with STDs, including HIV; (c) to take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.

**31.** Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.

**32.** Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the "best interest of the child" (art. 3).

**33.** With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment.

#### IV. VULNERABILITY AND RISK

**34.** In ensuring respect for the right of adolescents to health and development, both individual behaviours and environmental factors which increase their vulnerability and risk should be taken into consideration. Environmental factors, such as armed conflict or social exclusion, increase the vulnerability of adolescents to abuse, other forms of violence and exploitation, thereby severely limiting adolescents' abilities to make individual, healthy behaviour choices. For example, the decision to engage in unsafe sex increases adolescents' risk of ill-health.

**35.** In accordance with article 23 of the Convention, adolescents with mental and/or physical disabilities have an equal right to the highest attainable standard of physical and mental health. States parties have an obligation to provide adolescents with disabilities with the means necessary to realize their rights. [...] States parties should (a) ensure that health facilities, goods and services are available and accessible to all adolescents with disabilities and that these facilities and services promote their self-reliance and their active participation in the community; (b) ensure that the necessary equipment and personal support are available to enable them to move around, participate and communicate; (c) pay specific attention to the special needs relating to the sexuality of adolescents with disabilities; and (d) remove barriers that hinder adolescents with disabilities in realizing their rights.

**36.** States parties have to provide special protection to homeless adolescents, including those working in the informal sector. Homeless adolescents are particularly vulnerable to violence, abuse and sexual exploitation from others, self-destructive behaviour, substance abuse and mental disorders. In this regard, States parties are required to (a) develop policies and enact and enforce legislation that protect such adolescents from violence, e.g. by law enforcement officials; (b) develop strategies for the provision of appropriate education and access to health care, and of opportunities for the development of livelihood skills.

**37.** Adolescents who are sexually exploited, including in prostitution and pornography, are exposed to significant health risks, including STDs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress. They have the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity (art. 39). It is the obligation of States parties to enact and enforce laws to prohibit all forms of sexual exploitation and related trafficking; to collaborate with other States parties to eliminate intercountry trafficking; and to provide appropriate health and counselling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.

**38.** Additionally, adolescents experiencing poverty, armed conflicts, all forms of injustice, family breakdown, political, social and economic instability and all types of migration may be particularly vulnerable. These situations might seriously hamper their health and development. By investing heavily in preventive policies and measures States parties can drastically reduce levels of vulnerability and risk factors; they will also provide cost-effective ways for society to help adolescents develop harmoniously in a free society.

## V. NATURE OF STATES' OBLIGATIONS

**39.** In exercising their obligations in relation to the health and development of adolescents, States parties shall always take fully into account the four general principles of the Convention.

It is the view of the Committee that States parties must take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention. To this end, States parties must notably fulfil the following obligations:

- a.** To create a safe and supportive environment for adolescents, including within their family, in schools, in all types of institutions in which they may live, within their workplace and/or in the society at large;
- b.** To ensure that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices;
- c.** To ensure that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents;
- d.** To ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development;
- e.** To protect adolescents from all forms of labour which may jeopardize the enjoyment of their rights, notably by abolishing all forms of child labour and by regulating the working environment and conditions in accordance with international standards;
- f.** To protect adolescents from all forms of intentional and unintentional injuries, including those resulting from violence and road traffic accidents;
- g.** To protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation;
- h.** To ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations;
- i.** To implement measures for the prevention of mental disorders and the promotion of mental health of adolescents.

**40.** The Committee draws the attention of States parties to the general comment No. 14 on the right to the highest attainable standard of health of the Committee on Economic, Social and Cultural Rights which states that, "States parties should provide a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-sensitive health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."

**41.** In accordance with articles 24, 39 and other related provisions of the Convention, States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:

- a.** Availability. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;
- b.** Accessibility. Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;
- c.** Acceptability. While fully respecting the provisions and principles of the Convention, 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;
- d.** Quality. Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.

**42.** States parties should, where feasible, adopt a multisectoral approach to the promotion and protection of adolescent health and development by facilitating effective and sustainable linkages and partnerships among all relevant actors. At the national level, such an approach calls for close and systematic collaboration and coordination within Government, so as to ensure the necessary involvement of all relevant government entities. Public health and other services utilized by adolescents should also be encouraged and assisted in seeking collaboration with, *inter alia*, private and/or traditional practitioners, professional associations, pharmacies and organizations that provide services to vulnerable groups of adolescents.

**43.** A multisectoral approach to the promotion and protection of adolescent health and development will not be effective without international cooperation. Therefore, States parties should, when appropriate, seek such cooperation with United Nations specialized agencies, programmes and bodies, international NGOs and bilateral aid agencies, international professional associations and other non-State actors.

## NOTES

[1] These include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Elimination of All Forms of Racial Discrimination, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and the Convention on the Elimination of All Forms of Discrimination Against Women.

[2] See also the reports of the Committee's days of general discussion on "Violence against children" held in 2000 and 2001 and the Recommendations adopted in this regard (see CRC/C/100, chap. V and CRC/C/111, chap. V).

[3] Ibid.

[4] As proposed in the Framework Convention on Tobacco Control (2003) of the World Health Organization.

[5] For further guidance on this subject, refer to the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, (General Assembly resolution 46/119 of 17 December 1991, annex).

[6] Ibid., in particular principles 2, 3 and 7.

[7] For further guidance on this issue, see general comment No. 3 (2003) on HIV/AIDS and the rights of children.

[8] United Nations Standard Rules on Equal Opportunities for Persons with Disabilities.

Available online at:

[http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.4.En)

## 5/DEATH PENALTY

- Conference on the Abolition of the Death Penalty: Declaration of Stockholm (Amnesty International, 1977)
- Resolution on Physician Participation in Capital Punishment (World Medical Association, 1981, last revised 2000)
- Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty (UNESCO, 1984)
- Declaration on the Participation of Psychiatrists in the Death Penalty (World Psychiatric Association, 1989)
- Torture, Death Penalty and Participation by Nurses in Executions (International Council of Nurses, 1998, last revised 2006)
- Statement on the Participation of Health Personnel in the Death Penalty (Amnesty International, 2008)

### CONFERENCE ON THE ABOLITION OF THE DEATH PENALTY DECLARATION OF STOCKHOLM

*(Amnesty International, 1977)*

The Stockholm Conference on the Abolition of the Death Penalty, composed of more than 200 delegates and participants from Africa, Asia, Europe, the Middle East, North and South America and the Caribbean region,

#### **Recalls that:**

The death penalty is the ultimate cruel, inhuman and degrading punishment and violates the right to life.

#### **Considers that:**

- The death penalty is frequently used as an instrument of repression against opposition, racial, ethnic, religious and underprivileged groups;
- Execution is an act of violence, and violence tends to provoke violence;
- The imposition and infliction of the death penalty is brutalizing to all who are involved in the process;
- The death penalty has never been shown to have a special deterrent effect;
- The death penalty is increasingly taking the form of unexplained disappearances, extra-judicial executions and political murders;
- Execution is irrevocable and can be inflicted on the innocent.

**Affirms that:**

- It is the duty of the state to protect the life of all persons within its jurisdiction without exception;
- Executions for the purposes of political coercion, whether by government agencies or others, are equally unacceptable;
- Abolition of the death penalty is imperative for the achievement of declared international standards.

**Declares:**

- Its total and unconditional opposition to the death penalty;
- Its condemnation of all executions, in whatever form, committed or condoned by governments;
- Its commitment to work for the universal abolition of the death penalty.

**Calls upon:**

- Non-governmental organizations, both national and international, to work collectively and individually to provide public information materials directed towards the abolition of the death penalty;
- All governments to bring about the immediate and total abolition of the death penalty;
- The United Nations unambiguously to declare that the death penalty is contrary to international law.

Available online at: <http://www.uib.no/isf/people/amnesty/whatis04.htm>

**RESOLUTION ON PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT**

*(World Medical Association, 1981, 2000)*

Resolved, that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process.

Available online at: <http://www.wma.net/e/policy/c1.htm>

**SAFEGUARDS GUARANTEEING PROTECTION OF THE RIGHTS OF THOSE FACING THE DEATH PENALTY**

*(United Nations Economic and Social Council, 1984)*

1. In countries which have not abolished the death penalty, capital punishment may be imposed only for the most serious crimes, it being understood that their scope should not go beyond intentional crimes with lethal or other extremely grave consequences.
2. Capital punishment may be imposed only for a crime for which the death penalty is prescribed by law at the time of its commission, it being understood that

if, subsequent to the commission of the crime, provision is made by law for the imposition of a lighter penalty, the offender shall benefit thereby.

3. Persons below 18 years of age at the time of the commission of the crime shall not be sentenced to death, nor shall the death sentence be carried out on pregnant women, or on new mothers, or on persons who have become insane.
4. Capital punishment may be imposed only when the guilt of the person charged is based upon clear and convincing evidence leaving no room for an alternative explanation of the facts.
5. Capital punishment may only be carried out pursuant to a final judgement rendered by a competent court after legal process which gives all possible safeguards to ensure a fair trial, at least equal to those contained in article 14 of the International Covenant on Civil and Political Rights, including the right of anyone suspected of or charged with a crime for which capital punishment may be imposed to adequate legal assistance at all stages of the proceedings.
6. Anyone sentenced to death shall have the right to appeal to a court of higher jurisdiction, and steps should be taken to ensure that such appeals shall become mandatory.
7. Anyone sentenced to death shall have the right to seek pardon, or commutation of sentence; pardon or commutation of sentence may be granted in all cases of capital punishment.
8. Capital punishment shall not be carried out pending any appeal or other recourse procedure or other proceeding relating to pardon or commutation of the sentence.
9. Where capital punishment occurs, it shall be carried out so as to inflict the minimum possible suffering.

Adopted by Economic and Social Council resolution 1984/50 of 25 May 1984.

Available online at: [http://www.unhcr.ch/html/menu3/b/h\\_comp41.htm](http://www.unhcr.ch/html/menu3/b/h_comp41.htm)

## DECLARATION ON THE PARTICIPATION OF PSYCHIATRISTS IN THE DEATH PENALTY

*(World Psychiatric Association, 1989)*

The following declaration was adopted by the General Assembly of the World Psychiatric Association at its World Congress in Athens in October 1989.

- Psychiatrists are physicians and adhere to the Hippocratic Oath “to practice for the good of their patients and never to do harm”.
- The World Psychiatric Association is an international association with 77 Member Societies.

**Considering that** the United Nations’ Principles of Medical Ethics enjoins physicians – and thus psychiatrists – to refuse to enter into any relationship with a prisoner, other than one directed at evaluation, protecting or improving their physical and mental health, and further, considering that the Declaration of Hawaii of the WPA resolves that the psychiatrist shall serve the best interests of the patient and treat

every patient with the solicitude and respect due to the dignity of all human beings and that the psychiatrist must refuse to cooperate if some third party demands actions contrary to ethical principles.

Conscious that psychiatrists may be called on to participate in any action connected to executions, declares that the participation of psychiatrists in any such action is a violation of professional ethics.

Available online at: <http://www.wpanet.org/content/ethics-death-penalty.shtml>

## TORTURE, DEATH PENALTY AND PARTICIPATION BY NURSES IN EXECUTIONS

*(International Council of Nurses, 1998, 2003, 2006)*

### ICN POSITION

The International Council of Nurses strongly affirms that nurses should play no voluntary role in any deliberate infliction of physical or mental suffering and should not participate, either directly or indirectly, in the preparation for and the implementation of executions. To do otherwise is a clear violation of nursing's ethical code of practice.

The nurse's primary responsibility is to those people who require nursing care.

Nurses have a duty to provide the highest possible level of care to victims of cruel, degrading and inhumane treatment, and should speak up against and oppose any deliberate infliction of pain and suffering.

While ICN considers the death penalty to be unacceptable, clearly the nurse's responsibility to a prisoner sentenced to death continues until execution.

ICN urges its member national nurses' associations (NNAs) to lobby for abolition of the death penalty; to actively oppose torture and participation by nurses in executions; and to develop mechanisms to provide nurses with confidential advice and support in caring for prisoners sentenced to death or subjected to torture.

ICN pledges to take appropriate action and urges NNAs and individual nurses to do the same in support of nurses who become victims of torture, cruel treatment or even death for upholding the professional ethical conduct and for their work in defending human rights.

ICN believes that all levels of nursing education curricula should include: recognition of human rights issues and violations, such as torture and death penalty; awareness of the use of medical technology including lethal injections for executions; and recognition of the nurse's right to refuse to participate in executions.

### BACKGROUND

Violations of human rights are pervasive and scientific advances have brought about sophisticated forms of torture. ICN supports the United Nations Universal Declaration of Human Rights and advocates upholding the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the

Istanbul Protocol on Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[1]

The ICN Code of Ethics for Nurses states that the fundamental responsibility of the nurse is to promote health, prevent illness, to restore health and to alleviate suffering. However we recognise that nurses are sometimes called upon to perform physical examinations before prisoners' interrogation and torture, to attend torture sessions in order to provide care, and/or to treat the effects of torture.

Efforts to regulate and 'humanise' the death penalty or even to 'medicalise' it have led to contradictory legal and ethical problems.

## REFERENCES

[1] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) Submitted to the: United Nations High Commissioner for Human Rights 9 September 1999.

This statement replaces previous ICN Positions Nurses and Torture, adopted 1989 and Death penalty and participation by nurses in execution, adopted 1989.

Available online at: <http://www.icn.ch/pstorture.htm>

## STATEMENT ON THE PARTICIPATION OF HEALTH PERSONNEL IN THE DEATH PENALTY

*(Amnesty International, 2008)*

### PREAMBLE

#### **Bearing in mind that**

Under both international law and medical ethics, health professionals must never wilfully participate in the torture of prisoners or detainees nor in any other conduct that constitutes cruel, inhuman or degrading treatment or punishment;

The spirit of the Hippocratic Oath enjoins doctors to practice for the good of their patients and never to do harm;

The Declaration of Tokyo of the World Medical Association provides that "the utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity";

The World Medical Association, meeting in Lisbon in 1981, resolved that it is unethical for physicians to participate in capital punishment, and strengthened this resolution in 2000 (in Edinburgh, Scotland) to state that "it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process";

The World Psychiatric Association has declared that "Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed";

The United Nations' Principles of Medical Ethics of 1982 declared it "a contravention of medical ethics for health personnel, particularly physicians, to be

involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health”<sup>1</sup>;

Ethical dilemmas for health personnel can arise when they are called on to provide medical treatment to prisoners facing capital charges or sentenced to death, where such treatment could improve their health but could also facilitate their death by removing health-related obstacles to execution;

Health personnel can be called on to participate in executions by, *inter alia*:

- determining mental and physical fitness for execution;
- treating prisoners to restore mental or physical fitness in order that they may be executed;
- preparing, administering, supervising or advising others on any procedure related to execution;
- carrying out medical procedures to assist in bringing about the death of the prisoner;
- making medical examinations during executions, so that an execution can continue if the prisoner is not yet dead;
- pronouncing death after monitoring a prisoner’s vital signs;
- removing organs from the prisoner for transplantation purposes during or immediately after the execution.

Increasing numbers of professional bodies are opposing the death penalty in itself.

### Statement

Amnesty International believes that the any participation of health personnel in executions is a violation of professional ethics;

- Calls upon health personnel not to participate in executions;
- Further calls upon organizations of health professionals:
  - to protect health personnel who refuse to participate in executions;
  - to adopt policies, guidelines and standards of ethics proscribing participation by health personnel in executions;
  - to promote worldwide adherence to these standards through their active dissemination and awareness-raising among professional bodies;
  - to address breaches of these standards in appropriate ways;
  - to work for the abolition of the death penalty.

This statement is a revision of a declaration first adopted by Amnesty International in 1981. While Amnesty International’s principled position has remained unchanged, the text was revised in 1988 and 2008 in the light of further developments on the issue.

Available online at <http://www.amnesty.org/en/library/info/ACT50/021/2008/en>

---

1. UN Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture, and other cruel, inhuman or degrading treatment or punishment, Principle 3.

# 6/DEVELOPMENT

- Cairo Programme of Action (United Nations, 1994)
- Millennium Development Goals (United Nations, 2000)

## CAIRO PROGRAMME OF ACTION PROGRAMME OF ACTION OF THE UNITED NATIONS INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

*(United Nations, 1994)*

### CHAPTER VIII – HEALTH, MORBIDITY AND MORTALITY<sup>1</sup>

#### A. PRIMARY HEALTH CARE AND THE HEALTH-CARE SECTOR

##### Basis for action

**8.1** One of the main achievements of the twentieth century has been the unprecedented increase in human longevity. In the past half century, expectation of life at birth in the world as a whole has increased by about 20 years, and the risk of dying in the first year of life has been reduced by nearly two thirds. Nevertheless, these achievements fall short of the much greater improvements that had been anticipated in the World Population Plan of Action and the Declaration of Alma Ata, adopted by the International Conference on Primary Health Care in 1978. There remain entire national populations and sizeable population groups within many countries that are still subject to very high rates of morbidity and mortality. Differences linked to socio-economic status or ethnicity are often substantial. In many countries with economies in transition, the mortality rate has considerably increased as a result of deaths caused by accidents and violence.

**8.2** The increases in life expectancy recorded in most regions of the world reflect significant gains in public health and in access to primary health-care services. Notable achievements include the vaccination of about 80 per cent of the children in the world and the widespread use of low-cost treatments, such as oral rehydration therapy, to ensure that more children survive. Yet these achievements have not been realized in all countries, and preventable or treatable illnesses are still the leading killers of young children. Moreover, large segments of many populations continue to lack access to clean water and sanitation facilities, are forced to live in

---

1. The Cairo Programme of Action contains chapters on several other aspects of the links between population and sustainable development, which are not related directly to health and human rights. The full Cairo Programme of Action is available at the link given at the end of this selection.

congested conditions and lack adequate nutrition. Large numbers of people remain at continued risk of infectious, parasitic and water-borne diseases, such as tuberculosis, malaria and schistosomiasis. In addition, the health effects of environmental degradation and exposure to hazardous substances in the workplace are increasingly a cause of concern in many countries. Similarly, the growing consumption of tobacco, alcohol and drugs will precipitate a marked increase in costly chronic diseases among working age and elderly people. The impact of reductions in expenditures for health and other social services which have taken place in many countries as a result of public-sector retrenchment, misallocation of available health resources, structural adjustment and the transition to market economies has pre-empted significant changes in lifestyles, livelihoods and consumption patterns and is also a factor in increasing morbidity and mortality. Although economic reforms are essential to sustained economic growth, it is equally essential that the design and implementation of structural adjustment programmes incorporate the social dimension.

### **Objectives**

**8.3** The objectives are:

- a.** To increase the accessibility, availability, acceptability and affordability of health-care services and facilities to all people in accordance with national commitments to provide access to basic health care for all;
- b.** To increase the healthy life-span and improve the quality of life of all people, and to reduce disparities in life expectancy between and within countries.

### **Actions**

**8.4** All countries should make access to basic health care and health promotion the central strategies for reducing mortality and morbidity. Sufficient resources should be assigned so that primary health services attain full coverage of the population. Governments should strengthen health and nutrition information, education and communication activities so as to enable people to increase their control over and improve their health. Governments should provide the necessary backup facilities to meet the demand created.

**8.5** In keeping with the Declaration of Alma Ata, all countries should reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of the current decade. Countries should aim to achieve by 2005 a life expectancy at birth greater than 70 years and by 2015 a life expectancy at birth greater than 75 years. Countries with the highest levels of mortality should aim to achieve by 2005 a life expectancy at birth greater than 65 years and by 2015 a life expectancy at birth greater than 70 years. Efforts to ensure a longer and healthier life for all should emphasize the reduction of morbidity and mortality differentials between males and females as well as among geographical regions, social classes and indigenous and ethnic groups.

**8.6** The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies, and the reappraisal of primary health-care services, including reproductive health-care services to facilitate proper use of women's time, should be provided.

**8.7** Governments should ensure community participation in health policy planning, especially with respect to the long-term care of the elderly, those with disabilities and those infected with HIV and other endemic diseases. Such participation should also be promoted in child-survival and maternal health programmes, breast-feeding support programmes, programmes for the early detection and treatment of cancer of the reproductive system, and programmes for the prevention of HIV infection and other sexually transmitted diseases.

**8.8** All countries should re-examine training curricula and the delegation of responsibilities within the health-care delivery system in order to reduce frequent, unnecessary and costly reliance on physicians and on secondary- and tertiary-care facilities, while maintaining effective referral services. Access to health-care services for all people and especially for the most underserved and vulnerable groups must be ensured. Governments should seek to make basic health-care services more sustainable financially, while ensuring equitable access, by integrating reproductive health services, including maternal and child health and family-planning services, and by making appropriate use of community-based services, social marketing and cost-recovery schemes, with a view to increasing the range and quality of services available. The involvement of users and the community in the financial management of health-care services should be promoted.

**8.9** Through technology transfer, developing countries should be assisted in building their capacity to produce generic drugs for the domestic market and to ensure the wide availability and accessibility of such drugs. To meet the substantial increase in demand for vaccines, antibiotics and other commodities over the next decade and beyond, the international community should strengthen global, regional and local mechanisms for the production, quality control and procurement of those items, where feasible, in developing countries. The international community should facilitate regional cooperation in the manufacture, quality control and distribution of vaccines.

**8.10** All countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups through measures aimed at avoiding crowded housing conditions, reducing air pollution, ensuring access to clean water and sanitation, improving waste management, and increasing the safety of the workplace. Special attention should be given to the living conditions of the poor and disadvantaged in urban and rural areas. The impact of environmental problems on health, particularly that of vulnerable groups, should be monitored by Governments on a regular basis.

**8.11** Reform of the health sector and health policy, including the rational allocation of resources, should be promoted in order to achieve the stated objectives. All

Governments should examine ways to maximize the cost-effectiveness of health programmes in order to achieve increased life expectancy, reduce morbidity and mortality and ensure access to basic health-care services for all people.

## **B. CHILD SURVIVAL AND HEALTH**

### **Basis for action**

**8.12** Important progress has been made in reducing infant and child mortality rates everywhere. Improvements in the survival of children have been the main component of the overall increase in average life expectancy in the world over the past century, first in the developed countries and over the past 50 years in the developing countries. The number of infant deaths (i.e., of children under age 1) per 1,000 live births at the world level declined from 92 in 1970-1975 to about 62 in 1990-1995. For developed regions, the decline was from 22 to 12 infant deaths per 1,000 births, and for developing countries from 105 to 69 infant deaths per 1,000 births. Improvements have been slower in sub-Saharan Africa and in some Asian countries where, during 1990-1995, more than one in every 10 children born alive will die before their first birthday. The mortality of children under age 5 exhibits significant variations between and within regions and countries. Indigenous people generally have higher infant and child mortality rates than the national norm. Poverty, malnutrition, a decline in breast-feeding, and inadequacy or lack of sanitation and of health facilities are all factors associated with high infant and child mortality. In some countries, civil unrest and wars have also had major negative impacts on child survival. Unwanted births, child neglect and abuse are also factors contributing to the rise in child mortality. In addition, HIV infection can be transmitted from mother to child before or during childbirth, and young children whose mothers die are at a very high risk of dying themselves at a young age.

**8.13** The World Summit for Children, held in 1990, adopted a set of goals for children and development up to the year 2000, including a reduction in infant and under-5 child mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less. These goals are based on the accomplishments of child-survival programmes during the 1980s, which demonstrate not only that effective low-cost technologies are available but also that they can be delivered efficiently to large populations. However, the morbidity and mortality reductions achieved through extraordinary measures in the 1980s are in danger of being eroded if the broad-based health-delivery systems established during the decade are not institutionalized and sustained.

**8.14** Child survival is closely linked to the timing, spacing and number of births and to the reproductive health of mothers. Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where health-care facilities are scarce. Where infant mortality remains high, couples often have more children than they otherwise would to ensure that a desired number survive.

## Objectives

**8.15** The objectives are:

- a. To promote child health and survival and to reduce disparities between and within developed and developing countries as quickly as possible, with particular attention to eliminating the pattern of excess and preventable mortality among girl infants and children;
- b. To improve the health and nutritional status of infants and children;
- c. To promote breast-feeding as a child-survival strategy.

## Actions

**8.16** Over the next 20 years, through international cooperation and national programmes, the gap between average infant and child mortality rates in the developed and the developing regions of the world should be substantially narrowed, and disparities within countries, those between geographical regions, ethnic or cultural groups, and socio-economic groups should be eliminated. Countries with indigenous people should achieve infant and under-5 mortality levels among their indigenous people that are the same as those of the general population. Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under-5 mortality rate below 60 deaths per 1,000 births. By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further.

**8.17** All Governments should assess the underlying causes of high child mortality and should, within the framework of primary health care, extend integrated reproductive health-care and child-health services, including safe motherhood, child-survival programmes and family-planning services, to all the population and particularly to the most vulnerable and underserved groups. Such services should include prenatal care and counselling, with special emphasis on high-risk pregnancies and the prevention of sexually transmitted diseases and HIV infection; adequate delivery assistance; and neonatal care, including exclusive breast-feeding, information on optimal breast-feeding and on proper weaning practices, and the provision of micronutrient supplementation and tetanus toxoid, where appropriate. Interventions to reduce the incidence of low birth weight and other nutritional deficiencies, such as anaemia, should include the promotion of maternal nutrition through information, education and counselling and the promotion of longer intervals between births. All countries should give priority to efforts to reduce the major childhood diseases, particularly infectious and parasitic diseases, and to prevent malnutrition among children, especially the girl child, through measures aimed at eradicating poverty and ensuring that all children live in a sanitary environment and by disseminating information on hygiene and nutrition. It is also

important to provide parents with information and education about child care, including the use of mental and physical stimulation.

**8.18** For infants and children to receive the best nutrition and for specific protection against a range of diseases, breast-feeding should be protected, promoted and supported. By means of legal, economic, practical and emotional support, mothers should be enabled to breast-feed their infants exclusively for four to six months, without food or drink supplementation and to continue breast-feeding infants with appropriate and adequate complementary food up to the age of two years or beyond. To achieve these goals, Governments should promote public information on the benefits of breast-feeding; health personnel should receive training on the management of breast-feeding; and countries should examine ways and means to implement fully the WHO International Code of Marketing of Breast Milk Substitutes.

### **C. WOMEN'S HEALTH AND SAFE MOTHERHOOD**

#### **Basis for action**

**8.19** Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1988, it ranged from more than 700 per 100,000 live births in the least developed countries to about 26 per 100,000 live births in the developed regions. Rates of 1,000 or more maternal deaths per 100,000 live births have been reported in several rural areas of Africa, giving women with many pregnancies a high lifetime risk of death during their reproductive years. According to WHO, the lifetime risk of dying from pregnancy or childbirth-related causes is 1 in 20 in developing countries, compared to 1 in 10,000 in some developed countries. The age at which women begin or stop child-bearing, the interval between each birth, the total number of lifetime pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. At present, approximately 90 per cent of the countries of the world, representing 96 per cent of the world population, have policies that permit abortion under varying legal conditions to save the life of a woman. However, a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the women involved. Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children's health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for the maternal role. Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality.

## Objectives

**8.20** The objectives are:

- a. To promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. On the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion;
- b. To improve the health and nutritional status of women, especially of pregnant and nursing women.

## Actions

**8.21** Countries should strive to effect significant reductions in maternal mortality by the year 2015; a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realization of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.

**8.22** All countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care. These services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning. All births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. The underlying causes of maternal morbidity and mortality should be identified, and attention should be given to the development of strategies to overcome them and for adequate evaluation and monitoring mechanisms to assess the progress being made in reducing maternal mortality and morbidity and to enhance the effectiveness of ongoing programmes. Programmes and education to engage men's support for maternal health and safe motherhood should be developed.

**8.23** All countries, especially developing countries, with the support of the international community, should aim at further reductions in maternal mortality through measures to prevent, detect and manage high-risk pregnancies and births, particularly those to adolescents and late-parity women.

**8.24** All countries should design and implement special programmes to address the nutritional needs of women of child-bearing age, especially those who are pregnant or breast-feeding, and should give particular attention to the prevention and management of nutritional anaemia and iodine-deficiency disorders. Priority should be accorded to improving the nutritional and health status of young women through education and training as part of maternal health and safe motherhood programmes. Adolescent females and males should be provided with information, education and counselling to help them delay early family formation, premature sexual activity and first pregnancy.

**8.25** In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.

**8.26** Programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family-planning services. In order to reduce high-risk pregnancies, maternal health and safe motherhood programmes should include counselling and family-planning information.

**8.27** All countries, as a matter of some urgency, need to seek changes in high-risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

#### **D. HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)**

##### **Basis for action**

**8.28** The AIDS pandemic is a major concern in both developed and developing countries. WHO estimates that the cumulative number of AIDS cases in the world amounted to 2.5 million persons by mid-1993 and that more than 14 million people had been infected with HIV since the pandemic began, a number that is projected to rise to between 30 million and 40 million by the end of the decade, if effective prevention strategies are not pursued. As of mid-1993, about four fifths of all persons ever infected with HIV lived in developing countries where the infection

was being transmitted mainly through heterosexual intercourse and the number of new cases was rising most rapidly among women. As a consequence, a growing number of children are becoming orphans, themselves at high risk of illness and death. In many countries, the pandemic is now spreading from urban to rural areas and between rural areas and is affecting economic and agricultural production.

## Objectives

**8.29** The objectives are:

- a.** To prevent, reduce the spread of and minimize the impact of HIV infection; to increase awareness of the disastrous consequences of HIV infection and AIDS and associated fatal diseases, at the individual, community and national levels, and of the ways of preventing it; to address the social, economic, gender and racial inequities that increase vulnerability to the disease;
- b.** To ensure that HIV-infected individuals have adequate medical care and are not discriminated against; to provide counselling and other support for people infected with HIV and to alleviate the suffering of people living with AIDS and that of their family members, especially orphans; to ensure that the individual rights and the confidentiality of persons infected with HIV are respected; to ensure that sexual and reproductive health programmes address HIV infection and AIDS;
- c.** To intensify research on methods to control the HIV/AIDS pandemic and to find an effective treatment for the disease.

## Actions

**8.30** Governments should assess the demographic and development impact of HIV infection and AIDS. The AIDS pandemic should be controlled through a multisectoral approach that pays sufficient attention to its socio-economic ramifications, including the heavy burden on health infrastructure and household income, its negative impact on the labour force and productivity, and the increasing number of orphaned children. Multisectoral national plans and strategies to deal with AIDS should be integrated into population and development strategies. The socio-economic factors underlying the spread of HIV infection should be investigated, and programmes to address the problems faced by those left orphaned by the AIDS pandemic should be developed.

**8.31** Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasize behavioural change. Sex education and information should be provided to both those infected and those not infected, and especially to adolescents. Health providers, including family-planning providers, need training in counselling on sexually transmitted diseases and HIV infection, including the assessment and identification of high-risk behaviours needing special attention and services; training in the promotion of safe and responsible sexual behaviour, including voluntary abstinence, and condom use; training in the avoidance of contaminated equipment and blood products; and in the avoidance of sharing needles among injecting drug users. Governments should develop guidelines and counselling services on AIDS and sexually transmitted diseases

within the primary health-care services. Wherever possible, reproductive health programmes, including family-planning programmes, should include facilities for the diagnosis and treatment of common sexually transmitted diseases, including reproductive tract infection, recognizing that many sexually transmitted diseases increase the risk of HIV transmission. The links between the prevention of HIV infection and the prevention and treatment of tuberculosis should be assured.

**8.32** Governments should mobilize all segments of society to control the AIDS pandemic, including non-governmental organizations, community organizations, religious leaders, the private sector, the media, schools and health facilities. Mobilization at the family and community levels should be given priority. Communities need to develop strategies that respond to local perceptions of the priority accorded to health issues associated with the spread of HIV and sexually transmitted diseases.

**8.33** The international community should mobilize the human and financial resources required to reduce the rate of transmission of HIV infection. To that end, research on a broad range of approaches to prevent HIV transmission and to seek a cure for the disease should be promoted and supported by all countries. In particular, donor and research communities should support and strengthen current efforts to find a vaccine and to develop women-controlled methods, such as vaginal microbicides, to prevent HIV infection. Increased support is also needed for the treatment and care of HIV-infected persons and AIDS patients. The coordination of activities to combat the AIDS pandemic must be enhanced. Particular attention should be given to activities of the United Nations system at the national level, where measures such as joint programmes can improve coordination and ensure a more efficient use of scarce resources. The international community should also mobilize its efforts in monitoring and evaluating the results of various efforts to search for new strategies.

**8.34** Governments should develop policies and guidelines to protect the individual rights of and eliminate discrimination against persons infected with HIV and their families. Services to detect HIV infection should be strengthened, making sure that they ensure confidentiality. Special programmes should be devised to provide care and the necessary emotional support to men and women affected by AIDS and to counsel their families and near relations.

**8.35** Responsible sexual behaviour, including voluntary sexual abstinence, for the prevention of HIV infection should be promoted and included in education and information programmes. Condoms and drugs for the prevention and treatment of sexually transmitted diseases should be made widely available and affordable and should be included in all essential drug lists. Effective action should be taken to further control the quality of blood products and equipment decontamination.

United Nations International Conference on Population and Development (ICPD), 5-13 September 1994, Cairo, Egypt. Programme of Action of the United Nations International Conference on Population and Development.

Available online at: <http://www.iisd.ca/Cairo/program/p00000.html>

## MILLENNIUM DEVELOPMENT GOALS

*(United Nations, 2000)*

**Goal 1:** Eradicate Extreme Hunger and Poverty

*Target 1.* Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day

*Target 2.* Halve, between 1990 and 2015, the proportion of people who suffer from hunger

**Goal 2:** Achieve Universal Primary Education

*Target 3.* Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

**Goal 3:** Promote Gender Equality and Empower Women

*Target 4.* Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

**Goal 4:** Reduce Child Mortality

*Target 5.* Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

**Goal 5:** Improve Maternal Health

*Target 6.* Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

**Goal 6:** Combat HIV/AIDS, Malaria and other diseases

*Target 7.* Have halted by 2015 and begun to reverse the spread of HIV/AIDS

*Target 8.* Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

**Goal 7:** Ensure Environmental Sustainability

*Target 9.* Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources

*Target 10.* Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

*Target 11.* Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers

**Goal 8:** Develop a Global Partnership for Development

*Target 12.* Develop further an open, rule-based, predictable, non-discriminatory trading and financial system includes a commitment to good governance, development, and poverty reduction – both nationally and internationally

*Target 13.* Address the special needs of the least developed countries Includes: tariff and quota free access for least developed countries' exports; enhanced

programme of debt relief for HIPC countries and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

*Target 14.* Address the special needs of landlocked countries and small island developing States

*Target 15.* Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

*Target 16.* In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

*Target 17.* In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

*Target 18.* In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Details available online at: <http://www.un.org/millenniumgoals/goals.html>

For targets and indicators, see: <http://millenniumindicators.un.org/unsd/mdg/default.aspx>

# 7/DISABILITY

- Convention on the Rights of Persons with Disabilities (United Nations, 2006)

## CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

*(United Nations, 2006)*

### PREAMBLE

#### The States Parties to the present Convention,

- a. **Recalling** the principles proclaimed in the Charter of the United Nations which recognize the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world,
- b. **Recognizing** that the United Nations, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, has proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind,
- c. **Reaffirming** the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination,
- d. **Recalling** the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Rights of the Child, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,
- e. **Recognizing** that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,
- f. **Recognizing** the importance of the principles and policy guidelines contained in the World Programme of Action concerning Disabled Persons and in the Standard Rules on the Equalization of Opportunities for Persons with Disabilities in influencing the promotion, formulation and evaluation of the policies, plans, programmes and actions at the national, regional and

international levels to further equalize opportunities for persons with disabilities,

- g. Emphasizing** the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development,
- h. Recognizing** also that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person,
- i. Recognizing** further the diversity of persons with disabilities,
- j. Recognizing** the need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support,
- k. Concerned** that, despite these various instruments and undertakings, persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world,
- l. Recognizing** the importance of international cooperation for improving the living conditions of persons with disabilities in every country, particularly in developing countries,
- m. Recognizing** the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty,
- n. Recognizing** the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,
- o. Considering** that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them,
- p. Concerned** about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status,
- q. Recognizing** that women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,
- r. Recognizing** that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, and recalling obligations to that end undertaken by States Parties to the Convention on the Rights of the Child,
- s. Emphasizing** the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities,
- t. Highlighting** the fact that the majority of persons with disabilities live in conditions of poverty, and in this regard recognizing the critical need to address the negative impact of poverty on persons with disabilities,

- u. Bearing in mind** that conditions of peace and security based on full respect for the purposes and principles contained in the Charter of the United Nations and observance of applicable human rights instruments are indispensable for the full protection of persons with disabilities, in particular during armed conflicts and foreign occupation,
- v. Recognizing** the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms,
- w. Realizing** that the individual, having duties to other individuals and to the community to which he or she belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the International Bill of Human Rights,
- x. Convinced** that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities,
- y. Convinced** that a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries,

*Have agreed* as follows:

### **Article 1. Purpose**

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

### **Article 2. Definitions**

For the purposes of the present Convention:

**“Communication”** includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology;

**“Language”** includes spoken and signed languages and other forms of non spoken languages;

**“Discrimination on the basis of disability”** means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

**“Reasonable accommodation”** means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

**“Universal design”** means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. “Universal design” shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

### **Article 3. General principles**

The principles of the present Convention shall be:

- a. Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
- b. Non-discrimination;
- c. Full and effective participation and inclusion in society;
- d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e. Equality of opportunity;
- f. Accessibility;
- g. Equality between men and women;
- h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

### **Article 4. General obligations**

**1.** States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:

- a. To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
- b. To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- c. To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
- d. To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;

- e. To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;
  - f. To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;
  - g. To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;
  - h. To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;
  - i. To promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights.
2. With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.
  3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.
  4. Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent.
  5. The provisions of the present Convention shall extend to all parts of federal States without any limitations or exceptions.

#### **Article 5. Equality and non-discrimination**

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures which are necessary to accelerate or achieve *de facto* equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

#### **Article 6. Women with disabilities**

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

#### **Article 7. Children with disabilities**

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

#### **Article 8. Awareness-raising**

1. States Parties undertake to adopt immediate, effective and appropriate measures:
  - a. To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
  - b. To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
  - c. To promote awareness of the capabilities and contributions of persons with disabilities.
2. Measures to this end include:
  - a. Initiating and maintaining effective public awareness campaigns designed:
  - b. To nurture receptiveness to the rights of persons with disabilities;
  - c. To promote positive perceptions and greater social awareness towards persons with disabilities;

- d. To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market;
- e. Fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;
- f. Encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;
- g. Promoting awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities.

### **Article 9. Accessibility**

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, *inter alia*:
  - a. Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
  - b. Information, communications and other services, including electronic services and emergency services.
2. States Parties shall also take appropriate measures:
  - a. To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
  - b. To ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
  - c. To provide training for stakeholders on accessibility issues facing persons with disabilities;
  - d. To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
  - e. To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
  - f. To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
  - g. To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
  - h. To promote the design, development, production and distribution of accessible information and communications technologies and systems at an

early stage, so that these technologies and systems become accessible at minimum cost.

#### **Article 10. Right to life**

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

#### **Article 11. Situations of risk and humanitarian emergencies**

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

#### **Article 12. Equal recognition before the law**

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

#### **Article 13. Access to justice**

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

**Article 14. Liberty and security of person**

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

- a. Enjoy the right to liberty and security of person;
- b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

**Article 15. Freedom from torture or cruel, inhuman or degrading treatment or punishment**

1. 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 or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

**Article 16. Freedom from exploitation, violence and abuse**

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, *inter alia*, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of

persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

**5.** States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

### **Article 17. Protecting the integrity of the person**

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

### **Article 18. Liberty of movement and nationality**

**1.** States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including by ensuring that persons with disabilities:

- a.** Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;
- b.** Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;
- c.** Are free to leave any country, including their own;
- d.** Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.

**2.** Children with disabilities shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by their parents.

### **Article 19. Living independently and being included in the community**

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a.** Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- b.** Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent

isolation or segregation from the community;

c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

#### **Article 20. Personal mobility**

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

- a. Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
- b. Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
- c. Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
- d. Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

#### **Article 21. Freedom of expression and opinion, and access to information**

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

- a. Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;
- b. Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;
- c. Urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;
- d. Encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;
- e. Recognizing and promoting the use of sign languages.

#### **Article 22. Respect for privacy**

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to

unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

### **Article 23. Respect for home and the family**

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

- a. The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
- b. The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;
- c. Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

### **Article 24. Education**

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal

opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:

- a. The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
  - b. The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
  - c. Enabling persons with disabilities to participate effectively in a free society.
2. In realizing this right, States Parties shall ensure that:
    - a. Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
    - b. Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
    - c. Reasonable accommodation of the individual's requirements is provided;
    - d. Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
    - e. Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.
  3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:
    - a. Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;
    - b. Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;
    - c. Ensuring that the education of persons, and in particular children, who are blind, deaf or deaf-blind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development.
  4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

#### **Article 25. Health**

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

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

#### **Article 26. Habilitation and rehabilitation**

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- a. Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

- b. Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
- 2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
- 3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

### **Article 27. Work and employment**

1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labor market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, *inter alia*:
  - a. Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
  - b. Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;
  - c. Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;
  - d. Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;
  - e. Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;
  - f. Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;
  - g. Employ persons with disabilities in the public sector;
  - h. Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
  - i. Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
  - j. Promote the acquisition by persons with disabilities of work experience in the open labour market;

- k. Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.
- 2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

### **Article 28. Adequate standard of living and social protection**

- 1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.
- 2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:
  - a. To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
  - b. To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
  - c. To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability related expenses, including adequate training, counselling, financial assistance and respite care;
  - d. To ensure access by persons with disabilities to public housing programmes;
  - e. To ensure equal access by persons with disabilities to retirement benefits and programmes.

### **Article 29. Participation in political and public life**

States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake:

- a. To ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, *inter alia*, by:
  - i. Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
  - ii. Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;

- iii. Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice.
  - b. To promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:
    - i. Participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;
    - ii. Forming and joining organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

### **Article 30. Participation in cultural life, recreation, leisure and sport**

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:
  - a. Enjoy access to cultural materials in accessible formats;
  - b. Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
  - c. Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.
2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.
3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.
4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.
5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:
  - a. To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
  - b. To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;

- c. To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
- d. To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
- e. To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.

### **Article 31. Statistics and data collection**

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:
  - a. Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;
  - b. Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.
2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.
3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

### **Article 32. International cooperation**

1. States Parties recognize the importance of international cooperation and its promotion, in support of national efforts for the realization of the purpose and objectives of the present Convention, and will undertake appropriate and effective measures in this regard, between and among States and, as appropriate, in partnership with relevant international and regional organizations and civil society, in particular organizations of persons with disabilities. Such measures could include, *inter alia*:
  - a. Ensuring that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities;
  - b. Facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices;
  - c. Facilitating cooperation in research and access to scientific and technical knowledge;
  - d. Providing, as appropriate, technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies.
2. The provisions of this article are without prejudice to the obligations of each State Party to fulfil its obligations under the present Convention.

**Article 33. National implementation and monitoring**

1. States Parties, in accordance with their system of organization, shall designate one or more focal points within government for matters relating to the implementation of the present Convention, and shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels.
2. States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights.
3. Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process.

**Article 34. Committee on the Rights of Persons with Disabilities**

1. There shall be established a Committee on the Rights of Persons with Disabilities (hereafter referred to as “the Committee”), which shall carry out the functions hereinafter provided.
2. The Committee shall consist, at the time of entry into force of the present Convention, of twelve experts. After an additional sixty ratifications or accessions to the Convention, the membership of the Committee shall increase by six members, attaining a maximum number of eighteen members.
3. The members of the Committee shall serve in their personal capacity and shall be of high moral standing and recognized competence and experience in the field covered by the present Convention. When nominating their candidates, States Parties are invited to give due consideration to the provision set out in article 4, paragraph 3, of the present Convention.
4. The members of the Committee shall be elected by States Parties, consideration being given to equitable geographical distribution, representation of the different forms of civilization and of the principal legal systems, balanced gender representation and participation of experts with disabilities.
5. The members of the Committee shall be elected by secret ballot from a list of persons nominated by the States Parties from among their nationals at meetings of the Conference of States Parties. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.
6. The initial election shall be held no later than six months after the date of entry into force of the present Convention. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit the nominations within two months. The

Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating the State Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

**7.** The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election once. However, the term of six of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these six members shall be chosen by lot by the chairperson of the meeting referred to in paragraph 5 of this article.

**8.** The election of the six additional members of the Committee shall be held on the occasion of regular elections, in accordance with the relevant provisions of this article.

**9.** If a member of the Committee dies or resigns or declares that for any other cause she or he can no longer perform her or his duties, the State Party which nominated the member shall appoint another expert possessing the qualifications and meeting the requirements set out in the relevant provisions of this article, to serve for the remainder of the term.

**10.** The Committee shall establish its own rules of procedure.

**11.** The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention, and shall convene its initial meeting.

**12.** With the approval of the General Assembly of the United Nations, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

**13.** The members of the Committee shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

### **Article 35. Reports by States Parties**

**1.** Each State Party shall submit to the Committee, through the Secretary-General of the United Nations, a comprehensive report on measures taken to give effect to its obligations under the present Convention and on the progress made in that regard, within two years after the entry into force of the present Convention for the State Party concerned.

**2.** Thereafter, States Parties shall submit subsequent reports at least every four years and further whenever the Committee so requests.

**3.** The Committee shall decide any guidelines applicable to the content of the reports.

**4.** A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports, repeat information previously provided. When preparing reports to the Committee, States Parties are invited to consider doing so in an open and transparent process and to give due consideration to the provision set out in article 4, paragraph 3, of the present Convention.

**5.** Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

**Article 36. Consideration of reports**

1. Each report shall be considered by the Committee, which shall make such suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the State Party concerned. The State Party may respond with any information it chooses to the Committee. The Committee may request further information from States Parties relevant to the implementation of the present Convention.
2. If a State Party is significantly overdue in the submission of a report, the Committee may notify the State Party concerned of the need to examine the implementation of the present Convention in that State Party, on the basis of reliable information available to the Committee, if the relevant report is not submitted within three months following the notification. The Committee shall invite the State Party concerned to participate in such examination. Should the State Party respond by submitting the relevant report, the provisions of paragraph 1 of this article will apply.
3. The Secretary-General of the United Nations shall make available the reports to all States Parties.
4. States Parties shall make their reports widely available to the public in their own countries and facilitate access to the suggestions and general recommendations relating to these reports.
5. The Committee shall transmit, as it may consider appropriate, to the specialized agencies, funds and programmes of the United Nations, and other competent bodies, reports from States Parties in order to address a request or indication of a need for technical advice or assistance contained therein, along with the Committee's observations and recommendations, if any, on these requests or indications.

**Article 37. Cooperation between States Parties and the Committee**

1. Each State Party shall cooperate with the Committee and assist its members in the fulfilment of their mandate.
2. In its relationship with States Parties, the Committee shall give due consideration to ways and means of enhancing national capacities for the implementation of the present Convention, including through international cooperation.

**Article 38. Relationship of the Committee with other bodies**

In order to foster the effective implementation of the present Convention and to encourage international cooperation in the field covered by the present Convention:

- a. The specialized agencies and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite specialized agencies and

other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

**b.** The Committee, as it discharges its mandate, shall consult, as appropriate, other relevant bodies instituted by international human rights treaties, with a view to ensuring the consistency of their respective reporting guidelines, suggestions and general recommendations, and avoiding duplication and overlap in the performance of their functions.

#### **Article 39. Report of the Committee**

The Committee shall report every two years to the General Assembly and to the Economic and Social Council on its activities, and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

#### **Article 40. Conference of States Parties**

**1.** The States Parties shall meet regularly in a Conference of States Parties in order to consider any matter with regard to the implementation of the present Convention.

**2.** No later than six months after the entry into force of the present Convention, the Conference of States Parties shall be convened by the Secretary-General of the United Nations. The subsequent meetings shall be convened by the Secretary-General biennially or upon the decision of the Conference of States Parties.

#### **Article 41. Depositary**

The Secretary-General of the United Nations shall be the depositary of the present Convention.

#### **Article 42. Signature**

The present Convention shall be open for signature by all States and by regional integration organizations at United Nations Headquarters in New York as of 30 March 2007.

#### **Article 43. Consent to be bound**

The present Convention shall be subject to ratification by signatory States and to formal confirmation by signatory regional integration organizations. It shall be open for accession by any State or regional integration organization which has not signed the Convention.

#### **Article 44. Regional integration organizations**

**1.** “Regional integration organization” shall mean an organization constituted by sovereign States of a given region, to which its member States have transferred competence in respect of matters governed by the present Convention. Such

organizations shall declare, in their instruments of formal confirmation or accession, the extent of their competence with respect to matters governed by the present Convention. Subsequently, they shall inform the depositary of any substantial modification in the extent of their competence.

2. References to “States Parties” in the present Convention shall apply to such organizations within the limits of their competence.

3. For the purposes of article 45, paragraph 1, and article 47, paragraphs 2 and 3, of the present Convention, any instrument deposited by a regional integration organization shall not be counted.

4. Regional integration organizations, in matters within their competence, may exercise their right to vote in the Conference of States Parties, with a number of votes equal to the number of their member States that are Parties to the present Convention. Such an organization shall not exercise its right to vote if any of its member States exercises its right, and vice versa.

#### **Article 45. Entry into force**

1. The present Convention shall enter into force on the thirtieth day after the deposit of the twentieth instrument of ratification or accession.

2. For each State or regional integration organization ratifying, formally confirming or acceding to the present Convention after the deposit of the twentieth such instrument, the Convention shall enter into force on the thirtieth day after the deposit of its own such instrument.

#### **Article 46. Reservations**

1. Reservations incompatible with the object and purpose of the present Convention shall not be permitted.

2. Reservations may be withdrawn at any time.

#### **Article 47. Amendments**

1. Any State Party may propose an amendment to the present Convention and submit it to the Secretary-General of the United Nations. The Secretary-General shall communicate any proposed amendments to States Parties, with a request to be notified whether they favour a conference of States Parties for the purpose of considering and deciding upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of two thirds of the States Parties present and voting shall be submitted by the Secretary-General to the General Assembly of the United Nations for approval and thereafter to all States Parties for acceptance.

2. An amendment adopted and approved in accordance with paragraph 1 of this article shall enter into force on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the

date of adoption of the amendment. Thereafter, the amendment shall enter into force for any State Party on the thirtieth day following the deposit of its own instrument of acceptance. An amendment shall be binding only on those States Parties which have accepted it.

**3.** If so decided by the Conference of States Parties by consensus, an amendment adopted and approved in accordance with paragraph 1 of this article which relates exclusively to articles 34, 38, 39 and 40 shall enter into force for all States Parties on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the date of adoption of the amendment.

**Article 48. Denunciation**

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. The denunciation shall become effective one year after the date of receipt of the notification by the Secretary-General.

**Article 49. Accessible format**

The text of the present Convention shall be made available in accessible formats.

**Article 50. Authentic texts**

The Arabic, Chinese, English, French, Russian and Spanish texts of the present Convention shall be equally authentic.

IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective Governments, have signed the present Convention.

Available online at: <http://www.un.org/disabilities/default.asp?id=259>

## 8/DISAPPEARANCES

- 14-Point Programme for the Prevention of “Disappearances” (Amnesty International, 1992)
- International Convention for the Protection of All Persons from Enforced Disappearance (United Nations, 2006)

### 14-POINT PROGRAM FOR THE PREVENTION OF “DISAPPEARANCES”<sup>1</sup>

*(Amnesty International, 1992)*

The “disappeared” are people who have been taken into custody by agents of the state, yet whose whereabouts and fate are concealed, and whose custody is denied. “Disappearances” cause agony for the victims and their relatives. The victims are cut off from the world and placed outside the protection of the law; often they are tortured; many are never seen again. Their relatives are kept in ignorance, unable to find out whether the victims are alive or dead.

The United Nations has condemned “disappearances” as a grave violation of human rights and has said that their systematic practice is of the nature of a crime against humanity. Yet thousands of people “disappear” each year across the globe, and countless others remain “disappeared”. Urgent action is needed to stop “disappearances”, to clarify the fate of the “disappeared” and to bring those responsible to justice.

Amnesty International calls on all governments to implement the following 14-Point Program for the Prevention of “Disappearances”. It invites concerned individuals and organizations to join in promoting the program. Amnesty International believes that the implementation of these measures is a positive indication of a government’s commitment to stop “disappearances” and to work for their eradication worldwide.

---

1. When Amnesty International started to research and campaign on “disappearances” in the 1970s, international human rights law contained no definition of enforced disappearance. Amnesty International used the term “disappearance” to describe this human rights violation, in quotation marks to emphasize that in fact the victim had not, as the authorities often asserted, simply vanished, but that their whereabouts and fate, concealed from the outside world, were known by someone who decided what would happen to them and decided to conceal it. In December 2006 the UN [General Assembly] adopted the International Convention for the Protection of All Persons from Enforced Disappearance, which defines enforced disappearance in international law. Amnesty International’s policy now is to use the term and definition set out in the Convention, rather than the former terms “disappearance” or “disappeared”. Its 14-point programme will be revised and updated to reflect this change.

### **1. Official condemnation**

The highest authorities of every country should demonstrate their total opposition to “disappearances”. They should make clear to all members of the police, military and other security forces that “disappearances” will not be tolerated under any circumstances.

### **2. Chain-of-command control**

Those in charge of the security forces should maintain strict chain-of-command control to ensure that officers under their command do not commit “disappearances”. Officials with chain-of-command responsibility who order or tolerate “disappearances” by those under their command should be held criminally responsible for these acts.

### **3. Information on detention and release**

Accurate information about the arrest of any person and about his or her place of detention, including transfers and releases, should be made available promptly to relatives, lawyers and the courts. Prisoners should be released in a way that allows reliable verification of their release and ensures their safety.

### **4. Mechanism for locating and protecting prisoners**

Governments should at all times ensure that effective judicial remedies are available which enable relatives and lawyers to find out immediately where a prisoner is held and under what authority, to ensure his or her safety, and to obtain the release of anyone arbitrarily detained.

### **5. No secret detention**

Governments should ensure that prisoners are held only in publicly recognized places of detention. Up-to-date registers of all prisoners should be maintained in every place of detention and centrally. The information in these registers should be made available to relatives, lawyers, judges, official bodies trying to trace people who have been detained, and others with a legitimate interest. No one should be secretly detained.

### **6. Authorization of arrest and detention**

Arrest and detention should be carried out only by officials who are authorized by law to do so. Officials carrying out an arrest should identify themselves to the person arrested and, on demand, to others witnessing the event. Governments should establish rules setting forth which officials are authorized to order an arrest or detention. Any deviation from established procedures which contributes to a “disappearance” should be punished by appropriate sanctions.

### **7. Access to prisoners**

All prisoners should be brought before a judicial authority without delay after being taken into custody. Relatives, lawyers and doctors should have prompt and regular

access to them. There should be regular, independent, unannounced and unrestricted visits of inspection to all places of detention.

### **8. Prohibition in law**

Governments should ensure that the commission of a “disappearance” is a criminal offence, punishable by sanctions commensurate with the gravity of the practice. The prohibition of “disappearances” and the essential safeguards for their prevention must not be suspended under any circumstances, including states of war or other public emergency.

### **9. Individual responsibility**

The prohibition of “disappearances” should be reflected in the training of all officials involved in the arrest and custody of prisoners and in the instructions issued to them. They should be instructed that they have the right and duty to refuse to obey any order to participate in a “disappearance”. An order from a superior officer or a public authority must never be invoked as a justification for taking part in a “disappearance”.

### **10. Investigation**

Governments should ensure that all complaints and reports of “disappearances” are investigated promptly, impartially and effectively by a body which is independent of those allegedly responsible and has the necessary powers and resources to carry out the investigation. The methods and findings of the investigation should be made public. Officials suspected of responsibility for “disappearances” should be suspended from active duty during the investigation. Relatives of the victim should have access to information relevant to the investigation and should be entitled to present evidence. Complainants, witnesses, lawyers and others involved in the investigation should be protected from intimidation and reprisals. The investigation should not be curtailed until the fate of the victim is officially clarified.

### **11. Prosecution**

Governments should ensure that those responsible for “disappearances” are brought to justice. This principle should apply wherever such people happen to be, wherever the crime was committed, whatever the nationality of the perpetrators or victims and no matter how much time has elapsed since the commission of the crime. Trials should be in the civilian courts. The perpetrators should not benefit from any legal measures exempting them from criminal prosecution or conviction.

### **12. Compensation and rehabilitation**

Victims of “disappearance” and their dependants should be entitled to obtain fair and adequate redress from the state, including financial compensation. Victims who reappear should be provided with appropriate medical care or rehabilitation.

### 13. Ratification of human rights treaties and implementation of international standards

All governments should ratify international treaties containing safeguards and remedies against “disappearances”, including the International Covenant on Civil and Political Rights and its first Optional Protocol which provides for individual complaints. Governments should ensure full implementation of the relevant provisions of these and other international instruments, including the UN Declaration on the Protection of All Persons from Enforced Disappearance, and comply with the recommendations of intergovernmental organizations concerning these abuses.

### 14. International responsibility

Governments should use all available channels to intercede with the governments of countries where “disappearances” have been reported. They should ensure that transfers of equipment, know-how and training for military, security or police use do not facilitate “disappearances”. No one should be forcibly returned to a country where he or she risks being made to “disappear”.

Available online at: <http://www.amnesty.org/en/library/info/POL36/001/1993/en>

## INTERNATIONAL CONVENTION FOR THE PROTECTION OF ALL PERSONS FROM ENFORCED DISAPPEARANCE

*(United Nations, 2006)*

### PREAMBLE

The States Parties to this Convention,

**Considering the obligation** of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and fundamental freedoms,

**Having regard** to the Universal Declaration of Human Rights,

**Recalling** the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and all other relevant international instruments in the fields of human rights, humanitarian law and international criminal law,

**Recalling** the Declaration on the Protection of All Persons from Enforced Disappearance adopted by the General Assembly of the United Nations in its resolution 47/133 of 18 December 1992,

**Aware** of the extreme seriousness of enforced disappearance, which constitutes a crime and, in certain circumstances defined in international law, a crime against humanity,

**Determined** to prevent enforced disappearances and combat impunity for the crime of enforced disappearance,

**Considering** the right of any person not to be subjected to an enforced disappearance, the right of victims to justice and to reparation and,

**Affirming** the right to know the truth about circumstances of an enforced disappearance and the fate of the disappeared person, and the respect of the right to freedom to seek, receive and impart information to this end.

*Have agreed as follows:*

**Article 1**

1. No one shall be subjected to enforced disappearance.
2. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification for enforced disappearance.

**Article 2**

For the purposes of this Convention, enforced disappearance is considered to be the arrest, detention, abduction or any other form of deprivation of liberty committed by agents of the State or by persons or groups of persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law.

**Article 3**

Each State Party shall take appropriate measures to investigate acts defined in article 2 committed by persons or groups of persons acting without the authorization, support or acquiescence of the State and to bring those responsible to justice.

**Article 4**

Each State Party shall take the necessary measures to ensure that enforced disappearance constitutes an offence under its criminal law.

**Article 5**

The widespread or systematic practice of enforced disappearance constitutes a crime against humanity as defined in applicable international law and shall attract the consequences provided for under such applicable international law.

**Article 6**

1. Each State Party shall take the necessary measures to hold criminally responsible at least:
  - a. Any person who commits, orders, solicits or induces the commission of, attempts to commit, is an accomplice to or participates in an enforced disappearance;
  - b. The superior who:
    - i. Knew, or consciously disregarded information which clearly indicated, that subordinates under his or her effective authority and control were committing or about to commit a crime of enforced disappearance;

- ii. Exercised effective responsibility for and control over activities which were concerned with the crime of enforced disappearance; and
  - iii. Failed to take all necessary and reasonable measures within his or her power to prevent or repress the commission of the enforced disappearance or to submit the matter to the competent authorities for investigation and prosecution;
  - c. Subparagraph (b) above is without prejudice to the higher standards of responsibility applicable under relevant international law to a military commander or to a person effectively acting as a military commander.
2. No order or instruction from any public authority, civilian, military or other, may be invoked to justify an offence of enforced disappearance.

#### **Article 7**

1. Each State Party shall make the offence of enforced disappearance punishable by appropriate penalties which take into account its extreme seriousness.
2. Each State Party may establish:
  - a. Mitigating circumstances, in particular for persons who, having been implicated in the commission of an enforced disappearance, effectively contribute to bringing the disappeared person forward alive or make it possible to clarify cases of enforced disappearance or to identify the perpetrators of an enforced disappearance;
  - b. Without prejudice to other criminal procedures, aggravating circumstances, in particular in the event of the death of the disappeared person or the commission of an enforced disappearance in respect of pregnant women, minors, persons with disabilities or other particularly vulnerable persons.

#### **Article 8**

Without prejudice to article 5,

1. A State Party which applies a statute of limitations in respect of enforced disappearance shall take the necessary measures to ensure that the term of limitation for criminal proceedings:
  - a. Is of long duration and is proportionate to the extreme seriousness of this offence;
  - b. Commences from the moment when the offence of enforced disappearance ceases, taking into account its continuous nature.
2. Each State Party shall guarantee the right of victims of enforced disappearances to an effective remedy during the term of limitation.

#### **Article 9**

1. Each State Party shall take the necessary measures to establish its jurisdiction over the offence of enforced disappearance:
  - a. When the offence is committed in any territory under its jurisdiction or on board a ship or aircraft registered in that State;

- b. When the alleged offender is one of its nationals;
  - c. When the disappeared person is one of its nationals and the State Party considers it appropriate.
2. Each State Party shall likewise take such measures as may be necessary to establish its jurisdiction over the offence of enforced disappearance when the alleged offender is present in any territory under its jurisdiction, unless it extradites or surrenders him or her to another State in accordance with its international obligations or surrenders him or her to an international criminal tribunal whose jurisdiction it has recognized.
3. This Convention does not exclude any additional criminal jurisdiction exercised in accordance with national law.

### **Article 10**

1. Upon being satisfied, after an examination of the information available to it, that the circumstances so warrant, any State Party in whose territory a person alleged to have committed an offence of enforced disappearance is present shall take him or her into custody or take such other legal measures as are necessary to ensure his or her presence. The custody and other legal measures shall be as provided for in the law of that State Party but may be continued only for such time as is necessary to ensure the person's presence at criminal, surrender or extradition proceedings.
2. A State Party which has taken the measures referred to in paragraph 1 shall immediately carry out a preliminary inquiry or investigations to establish the facts. It shall notify the States Parties referred to in article 9, paragraph 1, of the measures it has taken in pursuance of paragraph 1 of this article, including detention and the circumstances warranting detention, and the findings of its preliminary inquiry or its investigations, indicating whether it intends to exercise its jurisdiction.
3. Any person in custody pursuant to paragraph 1 shall be assisted in communicating immediately with the nearest appropriate representative of the State of which he or she is a national, or, if he or she is a stateless person, with the representative of the State where he or she usually resides.

### **Article 11**

1. The State Party in the territory under whose jurisdiction a person alleged to have committed an offence of enforced disappearance is found shall, if it does not extradite that person or surrender him or her to another State in accordance with its international obligations or surrender him or her to an international criminal tribunal whose jurisdiction it has recognized, submit the case to its competent authorities for the purpose of prosecution.
2. These authorities shall take their decision in the same manner as in the case of any ordinary offence of a serious nature under the law of that State Party. In the cases referred to in article 9, paragraph 2, the standards of evidence required for prosecution and conviction shall in no way be less stringent than those which apply in the cases referred to in article 9, paragraph 1.

3. Any person against whom proceedings are brought in connection with an offence of enforced disappearance shall be guaranteed fair treatment at all stages of the proceedings. Any person tried for an offence of enforced disappearance shall benefit from a fair trial before a competent, independent and impartial court or tribunal established by law.

## **Article 12**

1. Each State Party shall ensure that any individual who alleges that a person has been subjected to enforced disappearance has the right to report the facts to the competent authorities, which shall examine the allegation promptly and impartially and, where appropriate, undertake without delay a thorough and impartial investigation. Appropriate steps shall be taken, where necessary, to ensure that the complainant, witnesses, relatives of the disappeared person and their defence counsel, as well as persons participating in the investigation, are protected against all ill-treatment or intimidation as a consequence of the complaint or any evidence given.
2. Where there are reasonable grounds for believing that a person has been subjected to enforced disappearance, the authorities referred to in paragraph 1 shall undertake an investigation, even if there has been no formal complaint.
3. Each State Party shall ensure that the authorities referred to in paragraph 1:
  - a. Have the necessary powers and resources to conduct the investigation effectively, including access to the documentation and other information relevant to their investigation;
  - b. Have access, if necessary with the prior authorization of a judicial authority, which shall rule promptly on the matter, to any place of detention or any other place where there are reasonable grounds to believe that the disappeared person may be present.
4. Each State Party shall take the necessary measures to prevent and sanction acts that hinder the conduct of the investigations. It shall ensure in particular that persons suspected of having committed an offence of enforced disappearance are not in a position to influence the progress of the investigations by means of pressure or acts of intimidation or reprisal aimed at the complainant, witnesses, relatives of the disappeared person or their defence counsel, or at persons participating in the investigation.

## **Article 13**

1. For the purposes of extradition between States Parties, the offence of enforced disappearance shall not be regarded as a political offence or as an offence connected with a political offence or as an offence inspired by political motives. Accordingly, a request for extradition based on such an offence may not be refused only on these grounds.
2. The offence of enforced disappearance shall be deemed to be included as an extraditable offence in any extradition treaty existing between States Parties before the entry into force of this Convention.

3. States Parties undertake to include the offence of enforced disappearance as an extraditable offence in any extradition treaty subsequently to be concluded between them.
4. If a State Party which makes extradition conditional on the existence of a treaty receives a request for extradition from another State Party with which it has no extradition treaty, it may consider this Convention as the necessary legal basis for extradition in respect of the offence of enforced disappearance.
5. States Parties which do not make extradition conditional on the existence of a treaty shall recognize the offence of enforced disappearance as an extraditable offence between themselves.
6. Extradition shall, in all cases, be subject to the conditions provided for by the law of the requested State Party or by applicable extradition treaties, including, in particular, conditions relating to the minimum penalty requirement for extradition and the grounds upon which the requested State Party may refuse extradition or make it subject to certain conditions.
7. Nothing in this Convention shall be interpreted as imposing an obligation to extradite if the requested State Party has substantial grounds for believing that the request has been made for the purpose of prosecuting or punishing a person on account of that person's sex, race, religion, nationality, ethnic origin, membership of a particular social group or political opinions, or that compliance with the request would cause harm to that person for any one of these reasons.

#### **Article 14**

1. States Parties shall afford one another the greatest measure of mutual legal assistance in connection with criminal proceedings brought in respect of an offence of enforced disappearance, including the supply of all evidence at their disposal that is necessary for the proceedings.
2. Such legal assistance shall be subject to the conditions provided for by the domestic law of the requested State Party or by applicable treaties on mutual legal assistance, including, in particular, the conditions in relation to the grounds upon which the requested State Party may refuse to grant mutual legal assistance or may make it subject to conditions.

#### **Article 15**

States Parties shall cooperate with each other and shall afford one another the greatest measure of assistance with a view to assisting victims of enforced disappearance, and in searching for, locating and releasing disappeared persons and, in the event of death, in exhuming and identifying them and returning their remains.

#### **Article 16**

1. No State Party shall expel, return ("refouler"), surrender or extradite a person to another State where there are substantial grounds for believing that he or she would be in danger of being subjected to enforced disappearance.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations, including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights or of serious violations of international humanitarian law.

### **Article 17**

1. No one shall be held in secret detention.
2. Without prejudice to other international obligations of the State Party with regard to the deprivation of liberty, each State Party shall, in its legislation:
  - a. Establish the conditions under which orders of deprivation of liberty may be given;
  - b. Indicate those authorities authorized to order the deprivation of liberty;
  - c. Guarantee that any person deprived of liberty shall be held solely in officially recognized and supervised places of deprivation of liberty;
  - d. Guarantee that any person deprived of liberty shall be authorized to communicate with and be visited by his or her family, counsel or any other person of his or her choice, subject only to the conditions established by law, or, if he or she is a foreigner, to communicate with his or her consular authorities, in accordance with applicable international law;
  - e. Guarantee access by the competent and legally authorized authorities and institutions to the places where persons are deprived of liberty, if necessary with the prior authorisation of a judicial authority;
  - f. Guarantee that any person deprived of liberty and, in the case of a suspected enforced disappearance, the person deprived of liberty not being able to exercise this right, that any person with a legitimate interest, such as relatives of the person deprived of liberty, their representative or their counsel, in all circumstances, shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of the deprivation of liberty and order the release if that deprivation of liberty is not lawful.
3. Each State Party shall assure the compilation and maintenance of one or more up-to-date official registers and/or records of persons deprived of liberty, which shall be made promptly available, upon request, to any judicial or other competent authority or institution authorized for that purpose by the law of the State Party concerned or any relevant international legal instrument to which the State concerned is a party. The information contained therein shall include, as a minimum:
  - a. The identity of the person deprived of liberty;
  - b. The date, time and location where the person was deprived of liberty and the identity of the authority who deprived the person of liberty;
  - c. The authority having decided the deprivation of liberty and the reasons for the deprivation of liberty;
  - d. The authority controlling the deprivation of liberty;

- e. The place of deprivation of liberty, the date and time of admission to the place of deprivation of liberty and the authority responsible for the place of deprivation of liberty;
- f. Elements regarding the physical integrity of the person deprived of liberty;
- g. In the event of death during the deprivation of liberty, the circumstances and cause of death and the destination of the human remains;
- h. The date and time of release or transfer to another place of detention, the destination and the authority responsible for the transfer.

### **Article 18**

1. Without prejudice to articles 19 and 20, each State Party shall guarantee to any person with a legitimate interest in this information, such as relatives of the person deprived of liberty, their representative or their counsel, access to at least the following information:
  - a. The authority having decided the deprivation of liberty;
  - b. The date, time and location where the person was deprived of liberty and admitted to the place of deprivation of liberty;
  - c. The authority controlling the deprivation of liberty;
  - d. The whereabouts of the person deprived of liberty, including, in the event of a transfer to another place of deprivation of liberty, the destination and the authority responsible for the transfer;
  - e. The date, time and place of release;
  - f. Elements regarding the physical integrity of the person deprived of liberty;
  - g. In the event of death during the deprivation of liberty, the circumstances and cause of death and the destination of the human remains.
2. Appropriate measures shall be taken, where necessary, to protect the persons referred to in paragraph 1, as well as persons participating in the investigation, from any ill-treatment, intimidation or sanction as a result of the search for information concerning a person deprived of liberty.

### **Article 19**

1. Personal information, including medical and genetic data, which are collected and/or transmitted within the framework of the search for a disappeared person shall not be used or made available for purposes other than the search for the disappeared person. This is without prejudice to the use of such information in criminal proceedings relating to an offence of enforced disappearance or the exercise of the right to obtain reparation.
2. The collection, processing, use and storage of personal information, including medical and genetic data, shall not infringe or have the effect of infringing the human rights, fundamental freedoms or human dignity of an individual.

### **Article 20**

1. Only when a person is under the protection of the law and the deprivation of

liberty is subject to judicial control, can the right to information referred to in Article 18 be restricted and only on an exceptional basis, where strictly necessary and provided for by law, and if the transmission of the information would undermine the privacy or safety of the person, hinder a criminal investigation, or for other equivalent reasons in accordance with the law, and in conformity with applicable international law and with the objectives of this Convention. In no case shall there be restrictions to the right to information referred to in article 18 that could constitute conduct defined in article 2 or be in violation of article 17, paragraph 1.

**2.** Without prejudice to consideration of the lawfulness of the deprivation of a person's liberty, States Parties shall guarantee to the persons referred to in article 18, paragraph 1 the right to a prompt and effective judicial remedy as a means of obtaining without delay information referred to in article 18, paragraph 1. This right to a remedy may not be suspended or restricted in any circumstances.

### **Article 21**

Each State Party shall take the necessary measures to ensure that persons deprived of liberty are released in a manner permitting reliable verification that they have actually been released. Each State Party shall also take the necessary measures to assure the physical integrity of such persons and their ability to exercise fully their rights at the time of release, without prejudice to any obligations to which such persons may be subject under national law.

### **Article 22**

Without prejudice to article 6, each State Party shall take the necessary measures to prevent and impose sanctions for the following conduct:

- a.** Delaying or obstructing the remedies referred to in article 17, paragraph 2 (f), and article 20, paragraph 2;
- b.** Failure to record the deprivation of liberty of any person, or the recording of any information which the official responsible for the official register and/or records knew or should have known to be inaccurate;
- c.** Refusal to provide information on the deprivation of liberty of a person, or the provision of inaccurate information, even though the legal requirements for providing such information have been met.

### **Article 23**

**1.** Each State Party shall ensure that the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody or treatment of any person deprived of liberty includes the necessary education and information regarding the relevant provisions of this Convention, in order to:

- a.** Prevent the involvement of such officials in enforced disappearances;
- b.** Emphasize the importance of prevention and investigations in relation to enforced disappearances;

- c. Ensure that the urgent need to resolve cases of enforced disappearance is recognized.
2. Each State Party shall ensure that orders or instructions prescribing, authorizing or encouraging enforced disappearance are prohibited. Each State Party shall guarantee that a person who refuses to obey such an order will not be punished.
  3. Each State Party shall take the necessary measures to ensure that the persons referred to in paragraph 1 who have reason to believe that an enforced disappearance has occurred or is planned report the matter to their superiors and, where necessary, to the appropriate authorities or organs vested with reviewing or remedial powers.

#### **Article 24**

1. For the purposes of this Convention, “victim” means the disappeared person and any individual who has suffered harm as a direct result of an enforced disappearance.
2. Each victim has the right to know the truth regarding the circumstances of the enforced disappearance, the progress and results of the investigation and the fate of the disappeared person. Each State Party shall take appropriate measures in this regard.
3. Each State Party shall take all appropriate measures to search for, locate and release disappeared persons and, in the event of death, to locate, respect and return their remains.
4. Each State Party shall ensure in its legal system that the victims of enforced disappearance have the right to obtain reparation and prompt, fair and adequate compensation.
5. The right to obtain reparation referred to in paragraph 4 covers material and psychological harm and, where appropriate, other means of reparation such as:
  - a. Restitution;
  - b. Rehabilitation;
  - c. Satisfaction, including restoration of dignity and reputation;
  - d. Guarantees of non-repetition.
6. Without prejudice to the obligation to continue the investigation until the fate of the disappeared person has been clarified, each State Party shall take the appropriate steps with regard to the legal situation of the disappeared persons whose fate has not been clarified and that of their relatives, in fields such as social welfare, financial matters, family law and property rights.
7. Each State Party shall guarantee the right to form and participate freely in organizations and associations concerned with contributing to the establishment of the circumstances of enforced disappearances and the fate of disappeared persons, and with assistance to victims of enforced disappearance.

#### **Article 25**

1. Each State Party shall take the necessary measures to prevent and punish under its criminal law:

- a. The wrongful removal of children who are subjected to enforced disappearance, children whose father, mother or legal guardian is subjected to enforced disappearance or children born during the captivity of a mother subjected to enforced disappearance;
  - b. The falsification, concealment or destruction of documents attesting to the true identity of the children referred to in subparagraph (a).
2. Each State Party shall take the necessary measures to search for and identify the children referred to in paragraph 1 (a) and to return them to their families of origin, in accordance with legal procedures and applicable international agreements.
  3. States Parties shall assist one another in searching for, identifying and locating the children referred to in paragraph 1 (a).
  4. Given the need to protect the best interests of the children referred to in paragraph 1 (a) and their right to preserve, or to have re-established, their identity, including their nationality, name and family relations as recognized by law, States Parties which recognize a system of adoption or other form of placement of children shall have legal procedures in place to review the adoption or placement procedure, and, where appropriate, to annul any adoption or placement of children that stemmed from an enforced disappearance.
  5. In all cases, and in particular in all matters relating to this article, the best interests of the child shall be a primary consideration, and a child who is capable of forming his or her own views shall have the right to express those views freely, the views of the child being given due weight in accordance with the age and maturity of the child.

## Article 26

1. A Committee on Enforced Disappearances (hereafter referred to as the Committee) shall be established to carry out the functions provided for under this Convention. The Committee shall consist of 10 experts of high moral character and recognised competence in the field of human rights, who shall serve in their personal capacity and be independent and impartial. The members of the Committee shall be elected by the States Parties according to equitable geographical distribution. Consideration shall be given to the usefulness of the participation to the work of the Committee of persons having relevant legal experience and to balanced gender representation.
2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by the States Parties from among their nationals, at biennial meetings of States Parties convened by the Secretary General of the United Nations for this purpose. At those meetings, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of votes of the representatives of States Parties present and voting.
3. The initial election shall be held no later than six months after the date of entry into force of this Convention. At least four months before the date of each election, the Secretary General of the United Nations shall address a letter to the States

Parties inviting them to submit the nominations within three months. The Secretary General shall prepare a list in alphabetical order of all persons thus nominated, indicating the State Party which nominated each candidate. He/She shall submit this list to all States Parties.

**4.** The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election once. However, the term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the chairman of the meeting referred to in paragraph 2 of this article.

**5.** If a member of the Committee dies or resigns or for any other cause can no longer perform his/her committee duties, the State Party which nominated him/her shall, in accordance with the criteria set out in paragraph 1 of this article, appoint another candidate from among its nationals, to serve for the remainder of his/her term, subject to the approval of the majority of the States Parties. The approval shall be considered given unless half or more of the States Parties respond negatively within six weeks after having been informed by the Secretary General of the United Nations of the proposed appointment.

**6.** The Committee shall establish its own rules of procedure.

**7.** The Secretary General of the United Nations shall provide the necessary means, staff and facilities for the effective performance of the functions of the Committee. The Secretary General of the United Nations shall convene the initial meeting of the Committee.

**8.** The members of the Committee shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

**9.** Each State Party shall co-operate with the Committee and assist its members in the fulfilment of their mandate, to the extent of the Committee's functions that the State Party has accepted.

### **Article 27**

A Conference of States Parties will take place at the earliest four years and at the latest six years following the entry into force of this Convention to evaluate the functioning of the Committee and to decide, in accordance with the procedure described in article 44, paragraph 2, whether it is appropriate to transfer to another body – without excluding any possibility – the monitoring of this Convention, in accordance with the functions defined in articles 28 to 36.

### **Article 28**

**1.** In the framework of the competencies granted by this Convention, the Committee shall co-operate with all relevant organs, offices and specialized agencies and funds of the United Nations, with the treaty bodies instituted by international instruments, with the special procedures of the United Nations, and with the regional intergovernmental organizations or bodies concerned, as well as with all

relevant State institutions, agencies or offices working toward the protection of all persons against enforced disappearances.

**2.** As it discharges its mandate, the Committee shall consult other treaty bodies instituted by relevant international human rights instruments, in particular the Human Rights Committee instituted by the International Covenant on Civil and Political Rights, with a view to ensuring the consistency of their respective observations and recommendations.

### **Article 29**

**1.** Each State Party shall submit to the Committee, through the Secretary-General of the United Nations, a report on the measures taken to give effect to its obligations under this Convention, within two years after the entry into force of this Convention for the State Party concerned.

**2.** The Secretary-General of the United Nations shall make this report available to all States Parties.

**3.** Each report shall be considered by the Committee, which shall issue such comments, observations or recommendations as it may deem appropriate. The comments, observations or recommendations shall be communicated to the State Party concerned, which may respond to them, on its own initiative or at the request of the Committee.

**4.** The Committee may also request further information from State Parties relevant to the implementation of this Convention.

### **Article 30**

**1.** A request that a disappeared person should be sought and found on an urgent basis may be submitted to the Committee by relatives of the disappeared person or their legal representatives, their counsel or any person authorized by them, as well as by any other person having a legitimate interest.

**2.** If the Committee considers that the request for urgent action submitted in pursuance of paragraph 1:

- a.** Is not manifestly unfounded;
- b.** Does not constitute an abuse of the right of submission of such requests;
- c.** Has already been duly presented to the competent bodies of the State Party concerned, such as investigative authorities, when this possibility exists;
- d.** Is not incompatible with the provisions of this Convention; and
- e.** The same matter is not being examined under another procedure of international investigation or settlement of the same nature; it shall request the State Party concerned to provide it with information on the situation of the person concerned, within a time limit set by the Committee.

**3.** In the light of the information provided by the State Party concerned in accordance with paragraph 2, the Committee may transmit recommendations to the State Party including a request that the State Party take all appropriate measures, including interim measures, to locate and protect the person in

accordance with this Convention and inform the Committee within a specified period of time, of measures taken, taking into account the urgency of the situation. The Committee shall inform the person submitting the urgent action request of its recommendations and of the information provided to it by the State as it becomes available.

4. The Committee shall continue its efforts to work with the State Party concerned for as long as the fate of the person sought remains unresolved. The person presenting the request shall be kept informed.

### **Article 31**

1. A State Party may at the time of ratification or at any time afterwards declare that it recognises the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction claiming to be victims of a violation by this State Party of the provisions of this Convention. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration.

2. The Committee shall consider a communication inadmissible when:

- a. The communication is anonymous;
- b. The communication constitutes an abuse of the right of submission of such communications or is incompatible with the provisions of this Convention;
- c. The same matter is being examined under another procedure of international investigation or settlement; or when
- d. All effective available domestic remedies have not been exhausted. This rule shall not apply where the application of the remedies is unreasonably prolonged.

3. If the Committee considers that the communication meets the requirements set out in paragraph 2, it shall transmit the communication to the State Party concerned, requesting it to provide observations and comments within a time limit set by the Committee.

4. At any time after the receipt of a communication and before a determination on the merits has been reached, the Committee may transmit to the State Party concerned for its urgent consideration a request that the State Party take such interim measures as may be necessary to avoid possible irreparable damage to the victim or victims of the alleged violation. Where the Committee exercises its discretion, this does not imply a determination on admissibility or on the merits of the communication.

5. The Committee shall hold closed meetings when examining communications under the present article. It shall inform the author of the communication of the responses provided by the State Party concerned. When the Committee decides to terminate the procedure it shall communicate its views to the State Party and to the author of the communication.

### **Article 32**

1. If the Committee receives reliable information indicating grave violations by a State Party of this Convention, it may, after consultation with the State Party concerned, request one or more of its members to undertake a visit and report back to it without delay.

2. The Committee shall notify the State Party concerned in writing of its intention to organise a visit, indicating the composition of the delegation and the purpose of the visit. The State Party shall answer the Committee within a reasonable time.
3. Upon a substantiated request by the State Party, the Committee may decide to postpone or cancel its visit.
4. If the State Party agrees to the visit, the Committee and the State Party concerned shall work together to define the modalities of the visit and the State Party shall provide the Committee with all the facilities needed for the successful completion of the visit.
5. Following its visit, the Committee shall communicate to the State Party concerned its observations and recommendations.

### **Article 33**

A State Party to this Convention may at any time declare that it recognises the competence of the Committee to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under this Convention. The Committee shall not receive communications concerning a State Party which has not made such a declaration, nor communications from a State Party which has not made such a declaration.

### **Article 34**

If the Committee receives information which appears to it to contain well-founded indications that enforced disappearance is being practised on a widespread or systematic basis in the territory under the jurisdiction of a State Party, it may, after seeking from the State Party concerned all relevant information on the situation, urgently bring the matter to the attention of the General Assembly of the United Nations, through the Secretary General of the United Nations.

### **Article 35**

1. The Committee shall have competence solely in respect of enforced disappearances which commenced after the entry into force of this Convention.
2. If a State becomes a party to this Convention after its entry into force, the obligations of that State *vis-à-vis* the Committee shall relate only to enforced disappearances which commenced after the entry into force of this Convention for the State concerned.

### **Article 36**

1. The Committee shall submit an annual report on its activities under this Convention to the States Parties and to the General Assembly of the United Nations.
2. Before an observation on a State Party is published in the annual report, the State Party concerned shall be informed in advance and shall be given reasonable time to answer. This State Party may request the publication of its comments or observations in the report.

**Article 37**

Nothing in this Convention shall affect any provisions which are more conducive to the protection of all persons from enforced disappearance and which may be contained in:

- a. The law of a State Party;
- b. International law in force for that State.

**Article 38**

1. This Convention is open for signature by all Member States of the United Nations Organisation.
2. This Convention is subject to ratification by all Member States of the United Nations Organisation. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
3. This Convention is open to accession by all Member States of the United Nations Organisation. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

**Article 39**

1. This Convention shall enter into force on the thirtieth day after the date of deposit of the twentieth instrument of ratification or accession.
2. For each State ratifying this Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, this Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

**Article 40**

The Secretary-General of the United Nations shall inform all States Members of the United Nations and all States which have signed this Convention or acceded to it of the following:

- a. Signatures, ratifications and accessions under article 38;
- b. The date of entry into force of this Convention under article 39.

**Article 41**

The provisions of this Convention shall extend to all parts of federal States without any limitations or exceptions.

**Article 42**

1. Any dispute between two or more States Parties concerning the interpretation or application of this Convention which cannot be settled through negotiation or by the procedures expressly provided for in this Convention shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the Parties are unable to agree on the organisation of the arbitration, any one of those Parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

2. Each State may, at the time of signature or ratification of this Convention or accession thereto, declare that it does not consider itself bound by paragraph 1 of this article. The other States Parties shall not be bound by paragraph 1 of this article with respect to any State Party having made such a declaration.

3. Any State Party having made a declaration in accordance with paragraph 2 of this article may at any time withdraw this declaration by notification to the Secretary-General of the United Nations.

#### **Article 43**

This Convention is without prejudice to the provisions of international humanitarian law, including the obligations of the High Contracting Parties to the four Geneva Conventions of 12 August 1949 and the additional protocols thereto of 8 June 1977, or to the opportunity available to any State Party to authorize the International Committee of the Red Cross to visit places of detention in situations not covered by international humanitarian law.

#### **Article 44**

1. Any State Party to this Convention may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to the States Parties to this Convention with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposal. In the event that within four months from the date of such communication at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations.

2. Any amendment adopted by a majority of two thirds of the States Parties present and voting at the conference shall be submitted by the Secretary-General to all the States Parties for acceptance.

3. An amendment adopted in accordance with paragraph 1 of this article shall enter into force when two thirds of the States Parties to this Convention have accepted it in accordance with their respective constitutional processes.

4. When amendments enter into force, they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of this Convention and any earlier amendment which they have accepted.

#### **Article 45**

1. This Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of this Convention to all States.

## 9/DISCRIMINATION

- Statement on Non-Discrimination in Professional Membership and Activities of Physicians (World Medical Association, 1985, 2005)

### STATEMENT ON NON-DISCRIMINATION IN PROFESSIONAL MEMBERSHIP AND ACTIVITIES OF PHYSICIANS

*(World Medical Association, 1985, 2005)*

*Adopted by the 37th World Medical Assembly, Brussels, Belgium, October 1985 and editorially revised with a name change at the 170th Council Session, Divonne-les-Bains, France, May 2005.*

The World Medical Association is in favour of equality of opportunity in medical association activities, medical education and training, employment, and all other medical professional endeavours regardless of race, colour, religion, creed, ethnic affiliation, national origin, sex, age or political affiliation.

The World Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in National Medical Associations to any duly registered physician because of race, colour, religion, creed, ethnic affiliation, national origin, sex, age or political affiliation.

The World Medical Association calls upon the medical profession and all individual members of National Medical Associations to exert every effort to prevent any instance in which such equal rights, privileges or responsibilities are denied.

Available online at: <http://www.wma.net/e/policy/f10.htm>

# 10/DUAL LOYALTIES

- Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms (International Dual Loyalty Working Group, 2002)

## DUAL LOYALTY AND HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE: PROPOSED GUIDELINES AND INSTITUTIONAL MECHANISMS

*(International Dual Loyalty Working Group, 2002)*

### PREAMBLE

These General Guidelines are designed to address how the health professional can

1. identify situations where subordination of patient interests to those of the state or other third party implicates human rights;
2. clarify the responsibilities of the health professional in these situations; and
3. in conjunction with the institutional mechanisms that follow, enable the health professional to respond appropriately, especially where the health professional faces personal or professional risks by adhering to obligations to the patient. Following these General Guidelines are specialized Guidelines designed to address particular concerns in high-risk clinical settings.

### SCOPE

These Guidelines apply to health professionals, such as physicians and nurses, as well as to health care personnel and health care auxiliaries who work under the supervision of health professionals. As explained in the Introduction, they apply in circumstances where the health professional is at risk of (a) subordinating loyalty to the patient to the interests of the state and (b) subordinating loyalty to the patient to the interests of a private non-state third party in circumstances where the state has an obligation to assure that private actors do not violate human rights. The guidelines apply to responsibilities of the health professional to individual patients. As noted in the introduction, there are circumstances where a health professional has responsibilities for communities of people – and these too may be subject to dual loyalty conflicts that implicate the human rights of all members of the community. References to “patient” or “clinical practice” in these Guidelines are meant to encompass responsibilities to communities as well, where applicable.

## GUIDELINES

**1.** The health professional should become conversant with human rights and the implications of human rights for clinical practice through study and training in human rights.

### *Commentary:*

The health professional's most fundamental responsibility in relation to the patient is to use medical skills to care for and promote the health, well-being, and human rights of the patient. Lack of awareness of human rights and their implications for clinical practice is one of the most significant factors leading to human rights violations against patients. Health professionals are not trained in human rights and generally have only the most vague understanding of the impact human rights obligations to patients should have on their relationships with state agents and state policies. Declarations of medical organizations, resource materials and curricula are available to health professionals but reach only a tiny proportion of licensed clinicians. Thus, training in basic human rights and their relationship to medical practice is a crucially important first step in addressing the dual loyalty and human rights problem. The scope of the understanding should include civil and political rights as well as economic, social, and cultural rights, and the indivisibility of such rights. This is essential so that health professionals can understand that their ethical obligations extend to the fulfillment of the rights to non-discrimination and to the highest attainable standard of health. Training should encompass an understanding of rights to information needed to protect health. Human-rights training is especially important in enabling health professionals to understand the impact on state policies and practices in clinical relationships within embers of traditionally marginalized groups, such as refugees, racial and ethnic minorities and women.

**2.** The health professional should develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised.

### *Commentary:*

Training in human rights is necessary but not sufficient to guarantee that health professionals will uphold their patients' human rights. As the case examples in Chapter II indicate, even when they have a general understanding of human rights, health professionals need to recognize situations where their own behavior toward the state and patient, including the clinical judgments they make, puts the human rights of their patients at risk. Health professionals must develop the skills to identify particular circumstances where dual loyalty concerns implicating human rights arise so that "alarm bells" go off in their minds. This is as important when they are passive bystanders to human rights abuses as when they are active perpetrators. Though they merely observe, the human rights abuses may nevertheless implicate them. An

important aspect of the educational process is to examine realistic case studies, including those relevant to local health care concerns and cultural practices, in order to become familiar with real-life problems of dual loyalty.

These skills should include the ability to understand not only where the state is itself violating human rights, but where it has failed to comply with its obligation to protect individuals from violations that may stem from common social practices like discrimination or abuses against women. For example, health professionals should understand how they may be implicated where the state has failed to protect women from female genital mutilation.

**3.** The health professional must place the protection of the patient's human rights and well-being first whenever there exists a conflict between the patient's human rights and the state's interests; this responsibility includes affirmatively resisting demands or requests by the state or third party interests to subordinate patient human rights to state or third party interests.

*Commentary:*

As noted above, the health professional has a fundamental obligation to uphold loyalty to the patient when doing otherwise would violate the patient's human rights, whether the violation is committed by the state or is a result of the state's failure to protect individuals from practices that violate human rights. Deference to cultural norms or social practices, such as denial of information about reproductive health to women, is not acceptable if those practices violate human rights. This Guideline should be applied in every dual loyalty and human rights conflict. The health professional should, however, become familiar with circumstances where adhering to state interests does not compromise human rights. Such circumstances include those justified by public health considerations, as set out in Guideline 7.

**4.** In all clinical assessments, whether for therapeutic or evaluative purposes, the health professional should exercise judgment independent of the interests of the state or other third party.

*Commentary:*

It is imperative that physicians and other health professionals apply their medical competencies to the needs of patients in an independent manner, preventing their judgments and actions from being controlled, dominated or influenced in any way by the interests of the state or other third party. Equally important, health professionals need to recognize circumstances where the state or other third party, overtly or subtly, seeks to compromise the independence of their judgments through rewards, incentives, demands, threats, or appeals to the political beliefs of the clinician. This includes whether an evaluation should be done at all, e.g., evaluations of women for "virginity" should be declined because the evaluation violates the woman's human rights.

**5.** The health professional should recognize how their professional skills can be misused by state agents to violate the human rights of individuals – especially in settings where human rights violations are pervasive – and take appropriate steps to avoid this misuse.

*Commentary:*

The health professional who cooperates with a regime in which human rights violations are pervasive may breach loyalty to the patient even if not an intentional perpetrator of abuses. Health professionals cannot insulate themselves from responsibility by turning aside from human rights violations that are often furthered by the state's reliance on their competencies, such as in involuntary sterilization or female genital mutilation.

Circumstances of indirect complicity in human rights violations include, but are not limited to, situations where the health professional's evaluations or treatment interventions are used by the state to assist in inflicting harm on individuals. For example, where torture is common, the torturers may rely on what seem to be otherwise independent clinical findings. Under this Guideline, a clinician has an obligation to assure that his or her professional skills are not misused, and if they are, to take actions set out in Guidelines 11 and 12.

**6.** The health professional should recognize that passive participation, or acquiescence, in violations of a patient's human rights is a breach of loyalty to the patient.

*Commentary:*

Circumstances and environments where human rights violations are institutionalized present the most difficult challenges to health professionals. Where, for example, women are denied access to birth control or immigrants are denied access to medical care, acquiescence by the health professional is the means by which the state achieves its objective of violating human rights. This Guideline means that passivity in the face of state requirements that violate patients' human rights is not excused.

**7.** The health professional should only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.

*Commentary:*

There exist many circumstances where strong state interests permit a health professional to subordinate patient interests to those of the state. These generally fall into the categories of promoting public health, serving important non-medical interests of the state or society (such as protecting third parties), and evaluating individuals for legitimate state purposes such as social benefits or criminal responsibility. For example, all three rationales have been invoked to breach patient confidentiality in particular circumstances.

These exceptions to the duty of absolute loyalty should be established only through legitimate processes and should be incorporated into ethical guidance provided to health professionals by national and international standard-setting bodies competent to define the ethical obligations of a health professional. “Competent” authorities are bodies that are both knowledgeable about medical ethics and free of undue state influence; a national medical organization operating under constraints of pressure from a repressive state is not considered competent. Similarly, “legitimate” implies appropriate mixtures of transparency, consultation and broad-based input in the formulation of such guidance by bodies that are sufficiently diverse in their constituencies, skills, and perspectives to capture adequately the implications of such policies for human rights.

In the absence of explicit Guidelines setting out the exceptions, the health professional should not engage in a process in which he or she weighs the interests of society or the state against the human rights of the individual. Rather, the clinician should only depart from loyalty to the patient when bona fide medical authorities authorize the departure.

This Guideline also means that the existence of a law requiring the health professional in a given circumstance to favor state interests over patient human rights does not absolve the health professional of the responsibility to uphold human rights. State demands reflected in law are only subject to deference if they are enacted in a procedurally appropriate way and if they are substantively consistent with human rights requirements and ethical standards. Health professionals have an obligation to be critical and vigilant of any legislative requirements that result in infringement of the rights of patients, and should seek guidance from appropriate authorities to resolve such conflicts.

It should also be noted that, in exceptional circumstances, a health professional may face a conflict where the rights of third parties are threatened by a state policy that mandates fidelity to the patient (such as proscribing notification the patient’s partner be of the patient’s sexually-transmitted diseases). Ethical considerations under these specific circumstances may justify departure from the principle of patient fidelity, and here the professional’s conflict with the state is of a different nature. Again, any decision to depart from fidelity to the patient should be within a recognized framework of exceptions. Where such guidance is unavailable, or does not stem from legitimate processes by bodies competent to develop such Guidelines, the health professional should seek to stimulate appropriate professional action to develop such Guidelines before undertaking any departure. Any departure from loyalty to them should be disclosed and the role the health professional is playing on behalf of the state as well as the reasons for it should be fully explained.

**8.** The health professional should maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.

*Commentary:*

An essential principle of medical ethics is that medical information about a patient shall be kept in strict confidentiality. This is particularly important with respect to disclosure to law enforcement agencies. There are, however, important exceptions to this principle – for example, where the health of a larger population or the well-being of an innocent third party could be affected. The health professional should not seek to determine the validity of such exceptions alone but instead should rely only on competent authorities in medical ethics, as provided in Guideline 7.

**9.** The health professional should take all possible steps to resist state demands to participation in a violation of the human rights of patients.

*Commentary:*

Although difficult to carry out when the environment is repressive and punitive, this Guideline is essential. When the health professional will suffer financial, psychological, or physical consequences for carrying out the duty of loyalty, medical authorities and peer organizations should provide the necessary aid and support (see chapter V on Institutional Mechanisms).

**10.** The health professional should act with an understanding of health professionals' collective obligation to uphold and promote the human rights and well-being of the patient.

*Commentary:*

In many clinical environments, there will be teams of health professionals, all of whom have a duty of loyalty to the patient. The success or failure of clinical consultation and consequent medical action often depends on the competencies and commitment of the range of health professionals. A key obligation, therefore, is solidarity among the health personnel to protect human rights. Delegation of decision-making to avoid dual loyalty conflicts that implicate human rights is inappropriate. This ethical solidarity also applies with respect to other health professionals at risk of reprisal for complying with their ethical and human rights responsibilities. Each health professional should cooperate with peers and colleagues to protect those subject to retaliation for protecting the human rights of patients.

**11.** The health professional should take advantage of opportunities for support from local, national and international professional bodies to meet their ethical and human rights duties to the patient.

*Commentary:*

When individuals or local groups of physicians and other health professionals are confronted with demands by the state to violate the human rights of patients on its behalf, they may be unable to counter that influence effectively on their own. They

may be subject to reprisals in employment and, in extreme cases, to legal harassment or even physical threats. As described in Chapter V, Institutional Mechanisms, it is the responsibility of associations of health professionals, locally, nationally and, when necessary, internationally, to protect health professionals at risk of such reprisals. The responsibility of the health professional to invoke the action of professional bodies is described further in Guideline 14. Recommendations for implementation of action by the professional bodies are contained in the chapter on institutional mechanisms.

**12.** The health professional should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities, both civil and medical.

*Commentary:*

A duty to report violations of human rights is necessary because a health professional cannot fulfil his duty of loyalty to patients if they are being subject to human rights violations that interfere with the medical service the professional provides or if the professional's services are being misused or manipulated by the state. Reporting the violations is often the only means by which the professional can end them so as to be able to fulfill ethical and human rights duties.

Wherever possible, the health professional should consult with the patient before reporting information to assure that the patient is not further abused as a result of reporting. If the patient does not agree to be identified, the health professional should consider reporting abuses in a manner that does not identify individuals. Also, the health professional should have confidence that the report is submitted to persons or entities that are in a position to stop the abuse or influence authorities to stop it. Depending on the circumstances, these may include state authorities, medical organizations, and colleagues. Before reporting such sensitive information to colleagues or medical associations, health professionals need to ensure the security of the information they entrust to others and have some clear picture about what they expect the recipient to do with it.

**13.** The health professional should act individually and collectively to bring an end to policies and practices that prevent the health professional from providing core health services to some or all patients in need. These practices include, among others, a state's failure to take steps needed to achieve the highest attainable standard of health for all; inequity in allocation of health resources or benefits; discrimination (or tolerance of discrimination) in health based on sex, race, ethnicity, class, sexual orientation, refugee and immigrant status, religion, language, caste or class or disability; denial of health information (such as information about reproductive health). This Guideline also applies in private settings where the state's obligations extend to ending discrimination and assuring the highest attainable standard of health.

*Commentary:*

Health professionals have an obligation to bring to an end practices that effectively lower the extent and quality of health services they provide to certain individuals. When the professional denies or limits appropriate care to an individual because of constraints caused by unfair or inequitable allocation of public resources, institutionalized discrimination, or state failure to address the needs of vulnerable groups, the professional becomes a vehicle or instrument by which a violation of the protection against discrimination or the right to the highest attainable standard of health takes place. Rather than adjust one's behavior to the constraints imposed by discrimination or the state's failure to develop a fair and equitable allocation of health resources, the health professional should act to change it. Health professionals can carry out this obligation in their own practices by being attentive to the standard of care they provide to their patients and acting to assure that their own practices do not reflect institutionalized discrimination or policies that otherwise violate the human rights of some or all of their patients. Thus, for example, they should never accede to state or cultural policies of racial or ethnic segregation in health, denial of appropriate clinical treatment of women (including reproductive health services), or refusal to offer care to undocumented workers. There are obvious limits to protecting patients' human rights, however, where the violations are structural and pervasive. In these instances the only means by which health professionals can protect, respect and fulfill the human rights of their patients is through collective action or through organizations of health care professionals, working to bring about a fairer and less discriminatory system.

**14.** The health professional should support colleagues individually and collectively – through professional bodies – when the state acts to impede or threaten their ability to fulfil their duty of loyalty to patients.

*Commentary:*

As noted above, there are many circumstances where individual health professionals are subject to pressures or threats, or even sheer indifference, by the state, when they act in ways that fulfill their duties to patients but contradict state policy. Collective action is necessary to provide redress, and each individual health professional has the responsibility to support colleagues at risk.

A Project of the International Dual Loyalty Working Group, a Collaborative Initiative of Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty, 2002.

Available online at: <http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf>

# 11/EXTRAJUDICIAL EXECUTIONS

- Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (United Nations, 1989)
- 14-Point Program for the Prevention of Extrajudicial Executions (Amnesty International, 1992)

## PRINCIPLES ON THE EFFECTIVE PREVENTION AND INVESTIGATION OF EXTRA-LEGAL, ARBITRARY AND SUMMARY EXECUTIONS

*(United Nations, 1989)*

### PREVENTION

1. Governments shall prohibit by law all extra-legal, arbitrary and summary executions and shall ensure that any such executions are recognized as offences under their criminal laws, and are punishable by appropriate penalties which take into account the seriousness of such offences. Exceptional circumstances including a state of war or threat of war, internal political instability or any other public emergency may not be invoked as a justification of such executions. Such executions shall not be carried out under any circumstances including, but not limited to, situations of internal armed conflict, excessive or illegal use of force by a public official or other person acting in an official capacity or a person acting at the instigation, or with the consent or acquiescence of such person, and situations in which deaths occur in custody. This prohibition shall prevail over decrees issued by governmental authority.
2. In order to prevent extra-legal, arbitrary and summary executions, Governments shall ensure strict control, including a clear chain of command over all officials responsible for the apprehension, arrest, detention, custody and imprisonment as well as those officials authorized by law to use force and firearms.
3. Governments shall prohibit orders from superior officers or public authorities authorizing or inciting other persons to carry out any such extra-legal, arbitrary or summary executions. All persons shall have the right and the duty to defy such orders. Training of law enforcement officials shall emphasize the above provisions.
4. Effective protection through judicial or other means shall be guaranteed to individuals and groups who are in danger of extra-legal, arbitrary or summary executions, including those who receive death threats.
5. No one shall be involuntarily returned or extradited to a country where there are substantial grounds for believing that he or she may become a victim of extra-legal, arbitrary or summary execution in that country.

6. Governments shall ensure that persons deprived of their liberty are held in officially recognized places of custody, and that accurate information on their custody and whereabouts, including transfers, is made promptly available to their relatives and lawyer or other persons of confidence.
7. Qualified inspectors, including medical personnel, or an equivalent independent authority, shall conduct inspections in places of custody on a regular basis, and be empowered to undertake unannounced inspections on their own initiative, with full guarantees of independence in the exercise of this function. The inspectors shall have unrestricted access to all persons in such places of custody, as well as to all their records.
8. Government shall make every effort to prevent extra-legal, arbitrary and summary executions through measures such as diplomatic intercession, improved access of complainants to intergovernmental and judicial bodies, and public denunciation. Intergovernmental mechanisms shall be used to investigate reports of any such executions and to take effective action against such practice. Governments, including those of countries where extra-legal, arbitrary and summary executions are reasonably suspected to occur, shall cooperate fully in international investigations on the subject.

## **INVESTIGATION**

9. There shall be a thorough, prompt and impartial investigation of all suspected cases of extra-legal, arbitrary and summary executions, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances. Governments shall maintain investigative offices and procedures to undertake such inquiries. The purpose of the investigation shall be to determine the cause, manner and time of death, the person responsible, and any pattern or practice which may have brought about that death. It shall include an adequate autopsy, collection and analysis of all physical and documentary evidence, and statements from witnesses. The investigation shall distinguish between natural death, accidental death, suicide and homicide.
10. The investigative authority shall have the power to obtain all the information necessary to the inquiry. Those persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige officials allegedly involved in any such executions to appear and testify. The same shall apply to any witness. To this end, they shall be entitled to issue summons to witnesses including the officials allegedly involved and to demand the production of evidence.
11. In cases in which the established investigative procedures are inadequate because of lack of expertise or impartiality, because of the importance of the matter or because of the apparent existence of a pattern of abuse, and in cases where there are complaints from the family of the victim about these inadequacies or other substantial reasons, Governments shall pursue investigations through an independent commission of inquiry or similar procedure. Members of such a

commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any institution, agency or person that may be the subject of the inquiry. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided under these Principles.

**12.** The body of the deceased person shall not be disposed of until an adequate autopsy is conducted by a physician, who shall, if possible, be an expert in forensic pathology. Those conducting the autopsy shall have the right of access to all investigative data, to the place where the body was discovered, and to the place where the death is thought to have occurred. If the body has been buried and it later appears that an investigation is required, the body shall be promptly and competently exhumed for an autopsy. If skeletal remains are discovered, they should be carefully exhumed and studied according to systematic anthropological techniques.

**13.** The body of the deceased shall be available to those conducting the autopsy for a sufficient amount of time to enable a thorough investigation to be carried out. The autopsy shall, at a minimum, attempt to establish the identity of the deceased and the cause and manner of death. The time and place of death shall also be determined to the extent possible. Detailed colour photographs of the deceased shall be included in the autopsy report in order to document and support the findings of the investigation. The autopsy report must describe any and all injuries to the deceased including any evidence of torture.

**14.** In order to ensure objective results, those conducting the autopsy must be able to function impartially and independently of any potentially implicated persons or organizations or entities.

**15.** Complainants, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation. Those potentially implicated in extra-legal, arbitrary or summary executions shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as over those conducting investigations.

**16.** Families of the deceased and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence. The family of the deceased shall have the right to insist that a medical or other qualified representative be present at the autopsy. When the identity of a deceased person has been determined, a notification of death shall be posted, and the family or relatives of the deceased immediately informed. The body of the deceased shall be returned to them upon completion of the investigation.

**17.** A written report shall be made within a reasonable period of time on the methods and findings of such investigations. The report shall be made public immediately and shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. The report shall also describe in detail specific

events that were found to have occurred, and the evidence upon which such findings were based, and list the names of witnesses who testified, with the exception of those whose identities have been withheld for their own protection. The Government shall, within a reasonable period of time, either reply to the report of the investigation, or indicate the steps to be taken in response to it.

### **LEGAL PROCEEDINGS**

**18.** Governments shall ensure that persons identified by the investigation as having participated in extra-legal, arbitrary and summary executions in any territory under their jurisdiction are brought to justice. Governments shall either bring such persons to justice or cooperate to extradite any such persons to other countries wishing to exercise jurisdiction. This principle shall apply irrespective of who and where the perpetrators or the victims are, their nationalities or where the offence was committed.

**19.** Without prejudice to Principle 3 above, an order from a superior officer or a public authority may not be invoked as a justification for extra-legal, arbitrary or summary executions. Superiors, officers or other public officials may be held responsible for acts committed by officials under their hierarchical authority if they had a reasonable opportunity to prevent such acts. In no circumstances including a state of war, siege or other public emergency, shall blanket immunity from prosecution be granted to any person allegedly involved in extra-legal, arbitrary or summary executions.

**20.** The families and dependents of victims of extra-legal, arbitrary and summary executions shall be entitled to fair and adequate compensation, within a reasonable period of time.

Available online at: <http://www.unhcr.ch/html/menu3/b/54.htm>

## **14-POINT PROGRAM FOR THE PREVENTION OF EXTRAJUDICIAL EXECUTIONS**

*(Amnesty International, 1992)*

Extrajudicial executions are fundamental violations of human rights and an affront to the conscience of humanity. These unlawful and deliberate killings, carried out by order of a government or with its complicity or acquiescence, have been condemned by the United Nations. Yet extrajudicial executions continue, daily and across the globe.

Many of the victims have been taken into custody or made to “disappear” before being killed. Some are killed in their homes, or in the course of military operations. Some are assassinated by uniformed members of the security forces, or by “death squads” operating with official connivance. Others are killed in peaceful demonstrations.

The accountability of governments for extrajudicial executions is not diminished by the commission of similar abhorrent acts by armed opposition

groups. Urgent action is needed to stop extrajudicial executions and bring those responsible to justice.

Amnesty International calls on all governments to implement the following 14-Point Program for the Prevention of Extrajudicial Executions. It invites concerned individuals and organizations to join in promoting the program. Amnesty International believes that the implementation of these measures is a positive indication of a government's commitment to stop extrajudicial executions and to work for their eradication worldwide.

### **1. Official condemnation**

The highest authorities of every country should demonstrate their total opposition to extrajudicial executions. They should make clear to all members of the police, military and other security forces that extrajudicial executions will not be tolerated under any circumstances.

### **2. Chain-of-command control**

Those in charge of the security forces should maintain strict chain-of-command control to ensure that officers under their command do not commit extrajudicial executions. Officials with chain-of-command responsibility who order or tolerate extrajudicial executions by those under their command should be held criminally responsible for these acts.

### **3. Restraints on use of force**

Governments should ensure that law enforcement officials use force only when strictly necessary and only to the minimum extent required under the circumstances. Lethal force should not be used except when strictly unavoidable in order to protect life.

### **4. Action against "death squads"**

"Death squads", private armies, criminal gangs and paramilitary forces operating outside the chain of command but with official support or acquiescence should be prohibited and disbanded. Members of such groups who have perpetrated extrajudicial executions should be brought to justice.

### **5. Protection against death threats**

Governments should ensure that anyone in danger of extrajudicial execution, including those who receive death threats, is effectively protected.

### **6. No secret detention**

Governments should ensure that prisoners are held only in publicly recognized places of detention and that accurate information about the arrest and detention of any prisoner is made available promptly to relatives, lawyers and the courts. No one should be secretly detained.

## **7. Access to prisoners**

All prisoners should be brought before a judicial authority without delay after being taken into custody. Relatives, lawyers and doctors should have prompt and regular access to them. There should be regular, independent, unannounced and unrestricted visits of inspection to all places of detention.

## **8. Prohibition in law**

Governments should ensure that the commission of an extrajudicial execution is a criminal offence, punishable by sanctions commensurate with the gravity of the practice. The prohibition of extrajudicial executions and the essential safeguards for their prevention must not be suspended under any circumstances, including states of war or other public emergency.

## **9. Individual responsibility**

The prohibition of extrajudicial executions should be reflected in the training of all officials involved in the arrest and custody of prisoners and all officials authorized to use lethal force, and in the instructions issued to them. These officials should be instructed that they have the right and duty to refuse to obey any order to participate in an extrajudicial execution. An order from a superior officer or a public authority must never be invoked as a justification for taking part in an extrajudicial execution.

## **10. Investigation**

Governments should ensure that all complaints and reports of extrajudicial executions are investigated promptly, impartially and effectively by a body which is independent of those allegedly responsible and has the necessary powers and resources to carry out the investigation. The methods and findings of the investigation should be made public. The body of the alleged victim should not be disposed of until an adequate autopsy has been conducted by a suitably qualified doctor who is able to function impartially. Officials suspected of responsibility for extrajudicial executions should be suspended from active duty during the investigation. Relatives of the victim should have access to information relevant to the investigation, should be entitled to appoint their own doctor to carry out or be present at an autopsy, and should be entitled to present evidence. Complainants, witnesses, lawyers, judges and others involved in the investigation should be protected from intimidation and reprisals.

## **11. Prosecution**

Governments should ensure that those responsible for extrajudicial executions are brought to justice. This principle should apply wherever such people happen to be, wherever the crime was committed, whatever the nationality of the perpetrators or victims and no matter how much time has elapsed since the commission of the crime. Trials should be in the civilian courts. The perpetrators should not be allowed to benefit from any legal measures exempting them from criminal prosecution or conviction.

**12. Compensation**

Dependants of victims of extrajudicial execution should be entitled to obtain fair and adequate redress from the state, including financial compensation.

**13. Ratification of human rights treaties and implementation of international standards**

All governments should ratify international treaties containing safeguards and remedies against extrajudicial executions, including the International Covenant on Civil and Political Rights and its first Optional Protocol which provides for individual complaints. Governments should ensure full implementation of the relevant provisions of these and other international instruments, including the UN Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions, and comply with the recommendations of intergovernmental organizations concerning these abuses.

**14. International responsibility**

Governments should use all available channels to intercede with the governments of countries where extrajudicial executions have been reported. They should ensure that training and transfers of equipment, know-how and training for military, security or police use do not facilitate extrajudicial executions. No one should be forcibly returned to a country where he or she risks becoming a victim of extrajudicial execution.

Available online at: <http://web.amnesty.org/pages/aboutai-recs-executions-eng>

# 12/FEMALE GENITAL MUTILATION

- Statement on Female Genital Mutilation (World Medical Association, 1993, last revised 2005)
- Resolution on Female Genital Mutilation (International Federation of Gynecology and Obstetrics, 1994)
- Position Statement on the Elimination of Female Genital Mutilation (International Council of Nurses, 1995, last revised 2004)
- Female Genital Mutilation (International Confederation of Midwives, 1999)
- Policy Statements Regarding the Prevention of FGM and the Management of Girls and Women with FGM Complications (World Health Organization, 2001)

## STATEMENT ON FEMALE GENITAL MUTILATION

*(World Medical Association, 1993, 2005)*

*Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005.*

### PREAMBLE

Female genital mutilation (FGM) is a common practice in over thirty countries. In many other countries the problem has arisen more recently due to the presence of ethnic groups from countries in which FGM is common practice, including immigrants and refugees who fled from hunger and war.

Because of its impact on the physical and mental health of women and children, FGM is a matter of concern to physicians. Physicians worldwide are confronted with the effects of this traditional practice. Sometimes they are asked to perform this mutilating procedure.

There are various forms of FGM. It can be a primary circumcision for young girls, usually between 5 and 12 years of age, or a secondary circumcision, e.g., after childbirth. The extent of a primary circumcision may vary: from an incision in the foreskin of the clitoris up to a pharaonic circumcision or infibulation removing the clitoris and labia minora and stitching up the labia majora so that only a minimal opening remains to allow for urine and menstrual blood.

Regardless of the extent of the circumcision, FGM affects the health of women and girls. Research evidence shows the grave permanent damage to health. Acute complications of FGM are: hemorrhage, infections, bleeding of adjacent organs, and excruciating pain. Long-term complications include severe scarring, chronic infections, urologic and obstetric complications, and psychological and social

problems. FGM has serious consequences for sexuality and how it is experienced. There is a multiplicity of complications during childbirth including expulsion disturbances, formation of fistulae, ruptures and incontinence.

Even with the least drastic version of circumcision, complications and functional consequences can occur, including the loss of all capacity for orgasm.

There are various reasons to explain the existence and continuation of the practice of FGM: custom, tradition (preserving virginity of young girls and limiting the sexual expression of women) and social reasons. These reasons do not justify the considerable damages to health.

None of the major religions supports this practice. The current medical opinion is that FGM is detrimental to the physical and mental health of girls and women. FGM is seen by many as a form of oppression of women.

By and large there is a strong tendency to condemn FGM more overtly:

- There are active campaigns against the practice in Africa. Many African women leaders as well as African heads of state have issued strong statements against the practice.
- International agencies such as the World Health Organization, the United Nations Commission on Human Rights and UNICEF have recommended that specific measures be aimed at the eradication of FGM.
- Governments in several countries have developed legislation, such as prohibiting FGM in their criminal codes.

## RECOMMENDATIONS

1. Taking into account the psychological needs and 'cultural identity' of the people involved, physicians should inform women, men and children about FGM and discourage them from performing or promoting FGM. Physicians should integrate health promotion and counselling against FGM into their work.
2. As a consequence, physicians should have adequate information and support for doing so. Educational programmes concerning FGM should be expanded and/or developed.
3. National Medical Associations should stimulate public and professional awareness of the damaging effects of FGM.
4. National Medical Associations should stimulate governmental action in preventing the practice of FGM.
5. National Medical Associations should cooperate in organising an appropriate preventive and legal strategy when a child is at risk of undergoing FGM.

## CONCLUSION

The World Medical Association condemns the practice of genital mutilation including the circumcision of women and girls and condemns the participation of physicians in such practices.

Available online at: <http://www.wma.net/e/policy/c10.htm>

## RESOLUTION ON FEMALE GENITAL MUTILATION

*(International Federation of Gynecology and Obstetrics, 1994)*

The FIGO General Assembly,

**considering** that Female Genital Mutilation (Female circumcision) is a harmful traditional practice which is still prevalent in over 30 countries of the world, including areas of Africa, Asia and the Middle East;

**concerned** about the serious adverse effects of this practice on the physical and psychological procedure performed on a child who cannot give informed consent;

**recognising** that Female Genital Mutilation is a violation of human rights, as a harmful procedure performed on a child who cannot give informed consent;

**recalling** the 1994 World Health Assembly Resolution WHA47.10 welcoming the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

1. *Invites* Member Societies to:
  - a. *Urge* their governments to ratify the Convention on the Elimination of ALL Forms of Discrimination Against Women, if they have not already done so, and to ensure the implementation of the articles of the Convention, if the Convention has already been ratified.
  - b. *Urge* their governments to take legal and/or other measures to render this practice socially unacceptable by all sectors and groups in society.
  - c. *Collaborate* with national authorities, non-governmental and inter-governmental organizations to advocate, promote and support measures aiming at the elimination of female genital mutilation.
2. *Recommends* that obstetricians and gynaecologists:
  - a. *Explain* the immediate dangers and long-term consequences of female genital mutilation to religious leaders, legislators and decision makers.
  - b. *Educate* health professionals, community workers and teachers about this harmful traditional practice.
  - c. *Support* those men and women who want to end the practice in their families or communities.
  - d. *Assist* in research for the documentation of the prevalence of the practice and its harmful consequences.
  - e. *Oppose* any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals.

Available online at:

[http://www.figo.org/projects/general\\_assembly\\_resolution\\_FGM](http://www.figo.org/projects/general_assembly_resolution_FGM)

## POSITION STATEMENT ON THE ELIMINATION OF FEMALE GENITAL MUTILATION<sup>1</sup>

*(International Council of Nurses, 1995, 2004)*

### ICN POSITION

Violence against women and girls in the form of female genital mutilation (FGM) constitutes a violation of basic human rights.

The International Council of Nurses (ICN) is unequivocal in its position of actively opposing FGM and any moves to 'medicalise' FGM – that is to perform the procedure in safe clinical conditions in order to reduce the health risks. ICN pledges to work to eliminate the practice of FGM by health professionals in any setting.

### BACKGROUND

The World Health Organization estimates that approximately 100 to 140 million women and girls have suffered FGM throughout the world and each year a further 2 million girls are at risk of the practice.<sup>2</sup> Therefore FGM is an issue for all nurses, as girls and women who have undergone FGM are likely to suffer significant physical, mental and psychological problems. The effects and complications of FGM are wide ranging, and require skilled management by informed, knowledgeable and culturally sensitive nurses and other health care providers. Therefore, these health care providers require education, not only about the physical and psychological aspects of FGM, treatment and care, but also about underlying socio-cultural, gender, economic and other factor factors required to raise the cultural sensitivity of carers.

Nurses, through their national nurses' associations, can undertake culturally informed, research-based programmes of information and education for nurses and other health care professionals on the nature, impact and issues involved in FGM. These also need to be directed towards the public, women, decision makers, religious leaders and other appropriate community groups. In addition, nurses can act individually, together, and with other organisations to discourage, prevent and eventually eliminate FGM. Nurses and national nurses associations can be critical in stimulating public and professional awareness of the physical and psychological toll of FGM on girls and women.

Approaches to the eradication of FGM must include collaborating with groups working in this field<sup>3</sup> to promote the inclusion of FGM counselling and treatment

---

1. This issue concerns all countries given the present patterns of immigration.

2. World Health Organization: <http://www.who.int/mediacentre/factsheets/fs241/en/index.html>, accessed March 2007.

3. Examples of NGOs with national groups addressing FGM include:

- The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) has a headquarters in Addis Ababa. IAC has 28 National Committees and 10 Group Sections in Europe, Japan and New Zealand.

- Foundation for Women's Health, Research and Development (FORWARD) in London.

- International Planned Parenthood Federation.

programmes in health services. Others, such as international intergovernmental and non-governmental organisations; other professionals; local religious leaders; women's groups; and pressure groups are potential allies when seeking to influence the adoption of appropriate policies, strategies and, where appropriate, the enactment of legislation.

Available online at: <http://www.icn.ch/psgenital.htm>

## STATEMENT ON FEMALE GENITAL MUTILATION

*(International Confederation of Midwives, 2005)*

### BACKGROUND

Female genital mutilation is defined to comprise all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

### CLASSIFICATION

Type I Excision of the prepuce with or without excision of part or all of the clitoris

Type II Excision of the clitoris with partial or total excision of the labia minora

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV Unclassified

- pricking, piercing or incising of the clitoris and/or labia
- stretching of the clitoris and/or labia
- cauterisation by burning of the clitoris and surrounding tissues
- scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts)
- introduction of corrosive substances or herbs into the vagina to cause bleeding, or for the purposes of tightening or narrowing it.
- any other procedure that falls under the definition of female genital mutilation given above.

The health consequences of female genital mutilation vary according to the type and severity of the procedure performed. Immediate complications include severe pain, shock, haemorrhage. Short-term complications include urine retention, ulceration of the genital region and injury to adjacent tissue. Long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction and difficulties with childbirth. As regards psychological health, genital mutilation may leave a lasting mark on the life and mind of those who have undergone it, with women suffering feelings of incompleteness, anxiety and depression.

More recently, concern has arisen about possible transmission of the human immunodeficiency virus (HIV) due to the use of one instrument in multiple operations, but this has not been the subject of detailed research.

## STATEMENT OF BELIEF

The ICM believes that practices which are harmful to the health of women or infant should be eliminated. It endorses the definition and classification of female genital mutilation set out above as adopted by WHO, UNICEF and UNFPA.

## POSITION

The ICM acknowledges there is a need for more extensive research on the physical and psychological impact on the health of girls and women who have undergone this procedure and urges all midwives to contribute to such research.

*The ICM resolves to:*

- advocate, on behalf of girls, women and midwives, for the elimination of female genital mutilation worldwide in the many international venues where the Confederation functions
- support Member Associations which seek to eliminate female genital mutilation in their country
- provide opportunities for midwives who attend the Confederation's international congresses or conferences to gain better knowledge of the practice and its health consequences
- join with other international and national organisations, both governmental and nongovernmental, in the adoption of appropriate policies, strategies, and, where possible, in the drafting of legislation, for the elimination of female genital mutilation
- urge midwifery organisations to advise midwives not to perform female genital mutilation.

## GUIDING STATEMENT TO MEMBER ASSOCIATIONS

Member Associations are urged, if they have not already done so, to adopt a policy which is in harmony with this statement.

## RELATED ICM DOCUMENTS

- ICM International Code of Ethics for Midwives (1993)

## OTHER RELEVANT DOCUMENTS

- Female Genital Mutilation, report of a WHO Technical Working Group, July, 1995.
- Female Genital Mutilation, an Overview, WHO, Geneva, 1998.
- Joint Statement WHO/UNICEF/UNFPA 1997
- Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. Report of a WHO Technical Consultation, Geneva, 15-17 October 1997.
- Regional plan of action to accelerate the elimination of Female Genital Mutilation in Africa, WHO 1997
- WHO Fact sheet 214. Female genital mutilation. Geneva, Switzerland: WHO, 2000.
- WHO. Female Genital Mutilation: Integrating the prevention and the

management of the health complications into the curricula of nursing and midwifery. Teacher's Manual and Student's Manual. Geneva, Switzerland: WHO.

Adopted at Brisbane Council meeting, 2005

Due for next review 2011

Available online at: <http://www.internationalmidwives.org/portals/5/Documentation/Female%20Genital%20Mutilation%202005.pdf>

## **POLICY STATEMENTS REGARDING THE PREVENTION OF FGM AND THE MANAGEMENT OF GIRLS AND WOMEN WITH FGM COMPLICATIONS**

*(World Health Organization, 2001)*

### **POLICY 1: OPENING UP OF TYPE III FGM (INFIBULATION)**

1. Nurses and midwives need to be trained to open up type III FGM, and their competency to perform the procedure maintained to ensure that care is safe and effective.
2. Nurses and midwives need to be given the administrative and legal authority to carry out the opening up procedure.

### **POLICY 2: REFUSAL OF REQUESTS TO RE-STITCH AN OPENED UP VULVA (RE-INFIBULATION)**

1. Health workers must not, under any circumstances, close up (re-infibulate) an opened vulva in a girl or woman with type III FGM in a manner that makes intercourse and childbirth difficult.
2. Nurses and midwives need to be given the administrative and legal authority to refuse a demand for reclosure, regardless of the client's cultural and social background.
3. Nurses and midwives need to be given appropriate training and support to enable them to counsel families who expect them to perform a re-infibulation.

### **POLICY 3: PERFORMANCE OF FUNCTIONS THAT ARE OUTSIDE THE NURSE'S/MIDWIFE'S LEGAL SCOPE OF PRACTICE**

1. Nurses and midwives need to be given the appropriate training, and the competency to perform all necessary functions maintained, to ensure that care is comprehensive, effective and safe.
2. Nurses and midwives need to be given the administrative and legal authority to perform, without undue restriction, the functions that may be necessary to treat the conditions they encounter as primary caregivers.

### **POLICY 4: DOCUMENTATION OF FGM**

1. The presence of FGM and related complications should be noted as a matter of routine in the clinical records of health service clients.
2. Health information systems should include appropriate data on FGM.

**POLICY 5: PREVENTION OF FEMALE GENITAL MUTILATION BY NURSES, MIDWIVES, AND OTHER HEALTH CARE PROFESSIONALS**

1. Nurses, midwives and other health care workers must be expressly forbidden to perform female genital mutilation.
2. Any nurse, midwife or other health care worker found performing, or reported to have performed, FGM should be brought to the attention of the appropriate authorities for professional discipline and/or legal action.

Available online at: [http://www.who.int/gender/other\\_health/guidelinesnursesmid.pdf](http://www.who.int/gender/other_health/guidelinesnursesmid.pdf)

## 13/HIV AND AIDS

- Ethical Aspects of HIV Infection and Reproduction (International Federation of Gynecology and Obstetrics, 1996)
- International Guidelines on HIV/AIDS and Human Rights (UNAIDS/OHCHR, 1996, 2002, last revised 2006)
- Declaration of Commitment on HIV/AIDS (United Nations General Assembly Special Session on HIV/AIDS, 2001)
- Political Declaration on HIV/AIDS (United Nations, 2006)
- Resolution on Combating HIV/AIDS (World Medical Association, 2006)
- Statement on HIV/AIDS and the Medical Profession (World Medical Association, 2006)

### ETHICAL ASPECTS OF HIV INFECTION AND REPRODUCTION

*(International Federation of Gynecology and Obstetrics, 1996)*

1. HIV infection is a transmissible disease with profound social and psychological implications for the woman, her partner and her family as well as for the health care team and society. Its characteristics include a prolonged latent period, a very high morbidity and mortality and social stigma. In addition, there is as yet no vaccine or curative treatment. Vertical transmission from mother to fetus, or to infant via breast-milk may occur. The incidence of this transmission may be reduced by drug therapy.
2. These facts bring sharply into focus the ethical conflict between patient privacy and confidentiality and the need to protect the sexual partners, the health care team and the public from a fatal communicable disease.
3. Because the disease has the potential of reaching epidemic proportions, the overriding consideration of infection control for the whole population comes into tension with the limits of individual rights. As well as aggressive educational programs, other measures that may be considered would be mandatory offering of antenatal screening and confidential disclosure of HIV status to sexual partners and to health care workers at risk of exposure. Information regarding numbers of seropositive individuals should be made available to public health officials.
4. Individuals who are informed of positive serostatus suffer severe psychological sequelae including the sense that they have been given a death sentence. Furthermore discrimination based on seropositivity in regard to housing, jobs and insurance exists. Physicians have a duty, therefore, to provide not only individual counsel and care for patients but also public advocacy to protect them from unfair and punitive actions.

5. While appreciating the importance of confidentiality and patient privacy, the ethical responsibility of individual patients to prevent harm to others still exists. Informed consent must be obtained prior to testing for HIV infection and communication of the resultant information. Every effort should be made through counselling to convince individual patients of their responsibility to others including the importance of allowing such information to be used to protect sexual partners and health care workers. If in spite of every effort, consent is not obtained and the risk of transmission is high in certain circumstances, with consultation, it may be justified to override patient confidentiality.

6. Assisted reproductive technology requires the elective donation of gametes, embryos or surrogate carriage of pregnancy. Because of the elective nature of this technology confidential counselling and testing can be done and inclusion of only those with negative HIV status is possible. To protect the interests of those at risk of unwanted exposure to HIV including the potential child, only seronegative individuals should be allowed to participate.

7. Breastfeeding: In societies where safe, affordable alternative methods of infant feeding are available, it may be unethical for an HIV infected mother to breastfeed her child. Where the risks of alternative infant feeding are high, the balance of risk to the infant may favor making breastfeeding ethically justified.

Available online at: <http://www.figo.org/docs/Ethics%20Guidelines.pdf>

## INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

*(UNAIDS/OHCHR, 1996, 2002, 2006)*

In 1996, the International Guidelines on HIV/AIDS and Human Rights were adopted by the Second International Consultation on HIV/AIDS and Human Rights. The Guidelines built on expert advice to integrate the principles and standards of international human rights law into the HIV/AIDS response. The Guidelines were updated in 2002.

**Guideline 1:** States should establish an effective national framework for their response to HIV/AIDS, which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

**Guideline 2:** States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

**Guideline 3:** States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their

provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

**Guideline 4:** States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

**Guideline 5:** States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

**Guideline 6 (as revised in 2002):** States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

**Guideline 7:** States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

**Guideline 8:** States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

**Guideline 9:** States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

**Guideline 10:** States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

**Guideline 11:** States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

**Guideline 12:** States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

Consolidated version of text available online at:

[http://www2.ohchr.org/english/issues/hiv/docs/consolidated\\_guidelines.pdf](http://www2.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf)

## DECLARATION OF COMMITMENT ON HIV/AIDS

*(United Nations General Assembly Special Session on HIV/AIDS, 2001)*

### “GLOBAL CRISIS – GLOBAL ACTION”

1. We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;
2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual;
3. Noting with profound concern, that by the end of the year 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;
4. Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;
5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit;

- 6.** Recalling and reaffirming our previous commitments on HIV/AIDS made through:
- The United Nations Millennium Declaration of 8 September 2000;
  - The Political Declaration and Further Actions and Initiatives to Implement the Commitments made at the World Summit for Social Development of 1 July 2000;
  - The Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of 10 June 2000;
  - Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development of 2 July 1999;
  - The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;
  - The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001;
  - The Declaration of the Ibero-America Summit of Heads of State of November 2000 in Panama;
  - The Caribbean Partnership Against HIV/AIDS, 14 February, 2001;
  - The European Union Programme for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001;
  - The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000;
  - The Central Asian Declaration on HIV/AIDS of 18 May 2001;
- 7.** Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;
- 8.** Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;
- 9.** Welcoming the commitments of African Heads of State or Government, at the Abuja Special Summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;
- 10.** Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV/AIDS, the Latin America region with 1.5 million people living with HIV/AIDS, and the Central and Eastern European region with very rapidly rising infection rates; and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;

11. Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;
12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;
13. Noting further that stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;
14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;
15. Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;
17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;
18. Recognizing the need to achieve the prevention goals set out in this Declaration in order to stop the spread of the epidemic and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;
19. Recognizing that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;
20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic, and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;
21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;
23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, *inter alia*, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;
24. Recognizing also that the cost availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;
25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continue to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people and recalling efforts to make drugs available at low prices for those in need;
26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations; and noting that the impact of international trade agreements on access to or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated;
27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North/South, South/South cooperation and triangular cooperation;
28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;
29. Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;
30. Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;

- 31.** Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;
- 32.** Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organizations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research-based pharmaceutical companies, trade unions, media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders are important;
- 33.** Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;
- 34.** Further acknowledging the efforts of international humanitarian organizations combating the epidemic, including among others the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;
- 35.** Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the UNAIDS Programme Coordinating Board; noting its endorsement in December 2000 of the Global Strategy Framework for HIV/AIDS, which could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;
- 36.** Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

## **LEADERSHIP**

Strong leadership at all levels of society is essential for an effective response to the epidemic.

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.

Leadership involves personal commitment and concrete actions.

## **AT THE NATIONAL LEVEL**

**37.** By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that: address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and

the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, *inter alia* international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

**38.** By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

#### **AT THE REGIONAL AND SUB-REGIONAL LEVEL**

**39.** Urge and support regional organizations and partners to: be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country level efforts;

**40.** Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum Consensus and Plan of Action: Leadership to Overcome HIV/AIDS; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Diseases; the CARICOM Pan-Caribbean Partnership Against HIV/AIDS; the ESCAP Regional Call for Action to Fight HIV/AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; the European Union Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction;

**41.** Encourage the development of regional approaches and plans to address HIV/AIDS;

**42.** Encourage and support local and national organizations to expand and strengthen regional partnerships, coalitions and networks;

**43.** Encourage the United Nations Economic and Social Council to request the regional commissions within their respective mandates and resources to support national efforts in their respective regions in combating HIV/AIDS;

#### **AT THE GLOBAL LEVEL**

**44.** Support greater action and coordination by all relevant United Nations system organizations, including their full participation in the development and implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in this Declaration;

**45.** Support greater cooperation between relevant United Nations system organizations and international organizations combating HIV/AIDS;

**46.** Foster stronger collaboration and the development of innovative partnerships between the public and private sectors and by 2003, establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

## **PREVENTION**

*Prevention must be the mainstay of our response*

**47.** By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

**48.** By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection;

**49.** By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS;

**50.** By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

**51.** By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;

**52.** By 2005, ensure that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

**53.** By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers;

**54.** By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

### **CARE, SUPPORT AND TREATMENT**

*Care, support and treatment are fundamental elements of an effective response*

**55.** By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organizations as well as with civil society and the business sector, to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, *inter alia* affordability and pricing, including differential pricing, and technical and health care systems capacity. Also, in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

**56.** By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psycho-social care;

**57.** By 2003, ensure that national strategies are developed in order to provide psycho-social care for individuals, families, and communities affected by HIV/AIDS;

### **HIV/AIDS AND HUMAN RIGHTS**

*Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS*

*Respect for the rights of people living with HIV/AIDS drives an effective response*

**58.** By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, *inter alia*, education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

**59.** By 2005, bearing in mind the context and character of the epidemic and that globally women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

**60.** By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

**61.** By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

## **REDUCING VULNERABILITY**

*The vulnerable must be given priority in the response*

*Empowering women is essential for reducing vulnerability*

**62.** By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and boys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

- 63.** By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, *inter alia*, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by: ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;
- 64.** By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements forced or otherwise;

### **CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS**

*Children orphaned and affected by HIV/AIDS need special assistance*

- 65.** By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;
- 66.** Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;
- 67.** Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa;

### **Alleviating social and economic impact**

*To address HIV/AIDS is to invest in sustainable development*

- 68.** By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of

national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs; adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

**69.** By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

### **Research and development**

*With no cure for HIV/AIDS yet found, further research and development is crucial*

**70.** Increase investment and accelerate research on the development of HIV vaccines, while building national research capacity especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development including biomedical, operations, social, cultural and behavioural research and in traditional medicine to: improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests, methods to prevent mother-to-child transmission; and improve our understanding of factors which influence the epidemic and actions which address it, *inter alia*, through increased funding and public/private partnerships; create a conducive environment for research and ensure that it is based on highest ethical standards;

**71.** Support and encourage the development of national and international research infrastructure, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of rapid expansion of the epidemic;

**72.** Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions, and drug resistance, develop methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

**73.** Strengthen international and regional cooperation in particular North/South, South/South and triangular cooperation, related to transfer of relevant technologies,

suitable to the environment in prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage that the end results of these cooperative research findings and technologies be owned by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

**74.** By 2003, ensure that all research protocols for the investigation of HIV-related treatment including anti-retroviral therapies and vaccines based on international guidelines and best practices are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

### **HIV/AIDS IN CONFLICT AND DISASTER AFFECTED REGIONS**

*Conflicts and disasters contribute to the spread of HIV/AIDS*

**75.** By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

**76.** Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

**77.** By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

**78.** By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

### **RESOURCES**

*The HIV/AIDS challenge cannot be met without new, additional and sustained resources*

**79.** Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

- 80.** By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between US\$ 7 billion and US\$ 10 billion in low- and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that needed resources are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;
- 81.** Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;
- 82.** Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required and ensure that adequate allocations are made by all ministries and other relevant stakeholders;
- 83.** Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking of 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries as agreed, as soon as possible, taking into account the urgency and gravity of the HIV/AIDS epidemic;
- 84.** Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;
- 85.** Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate and encourage the most effective and transparent use of all resources allocated;
- 86.** Call on the international community and invite civil society and the private sector to take appropriate measures to help alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;
- 87.** Without further delay implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those most affected by HIV/AIDS, in return for their making demonstrable commitments to poverty eradication and urge the use of debt service savings to finance poverty eradication programmes, particularly for HIV/AIDS prevention, treatment, care and support and other infections;
- 88.** Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including,

as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

**89.** Encourage increased investment in HIV/AIDS-related research, nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

**90.** Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments *inter alia* in their efforts to combat HIV/AIDS with due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

**91.** By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute to the global HIV/AIDS and health fund;

**92.** Direct increased funding to national, regional and subregional commissions and organizations to enable them to assist Governments at the national, subregional and regional level in their efforts to respond to the crisis;

**93.** Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of this Declaration;

## **FOLLOW-UP**

*Maintaining the momentum and monitoring progress are essential*

### **At the national level**

**94.** Conduct national periodic reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews;

**95.** Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

**96.** By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

### **At the regional level**

**97.** Include HIV/AIDS and related public health concerns as appropriate on the agenda of regional meetings at the ministerial and Head of State and Government level;

**98.** Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organizations of progress in implementing regional strategies and addressing regional priorities and ensure wide dissemination of the results of these reviews;

**99.** Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in this Declaration, and in particular facilitate intensified South-South and triangular cooperation;

#### **At the global level**

**100.** Devote sufficient time and at least one full day of the annual General Assembly session to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in this Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

**101.** Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

**102.** Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in this Declaration and in this regard encourage participation in and wide dissemination of the outcomes of: the forthcoming Dakar Conference on Access to Care for HIV Infection; the Sixth International Congress on AIDS in Asia and the Pacific; the XII International Conference on AIDS and Sexually Transmitted Infections in Africa; the XIV International Conference on AIDS, Barcelona; the Xth International Conference on People Living with HIV/AIDS, Port of Spain; the II Forum and III Conference of the Latin American and the Caribbean Horizontal Technical Cooperation on HIV/AIDS and Sexually Transmitted Infections, La Habana; the Vth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Changmai, Thailand;

**103.** Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organizations and other concerned partners, systems for voluntary monitoring and reporting of global drug prices;

*We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;*

*We look forward to strong leadership by Governments, and concerted efforts with full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;*

*And finally, we call on all countries to take the necessary steps to implement this Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.*

*Adopted by General Assembly resolution S-26/2 of 27 June 2001*

Available online at:

<http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

## POLITICAL DECLARATION ON HIV/AIDS

*(United Nations General Assembly, 2006)*

### **POLITICAL DECLARATION ON HIV/AIDS**

1. We, Heads of State and Government and representatives of States and Governments participating in the comprehensive review of the progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS,<sup>1</sup> held on 31 May and 1 June 2006, and the High-Level Meeting, held on 2 June 2006;
2. Note with alarm that we are facing an unprecedented human catastrophe; that a quarter of a century into the pandemic, AIDS has inflicted immense suffering on countries and communities throughout the world; and that more than 65 million people have been infected with HIV, more than 25 million people have died of AIDS, 15 million children have been orphaned by AIDS and millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 per cent of whom live in developing countries;
3. Recognize that HIV/AIDS constitutes a global emergency and poses one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large, and requires an exceptional and comprehensive global response;
4. Acknowledge that national and international efforts have resulted in important progress since 2001 in the areas of funding, expanding access to HIV prevention, treatment, care and support and in mitigating the impact of AIDS, and in reducing HIV prevalence in a small but growing number of countries, and also acknowledge that many targets contained in the Declaration of Commitment on HIV/AIDS have not yet been met;
5. Commend the Secretariat and the Co-sponsors of the Joint United Nations Programme on HIV/AIDS for their leadership role on HIV/AIDS policy and coordination, and for the support they provide to countries through the Joint Programme;
6. Recognize the contribution of, and the role played by, various donors in combating HIV/AIDS, as well as the fact that one third of resources spent on HIV/AIDS responses in 2005 came from the domestic sources of low- and middle-income countries, and therefore emphasize the importance of enhanced international cooperation and partnership in our responses to HIV/AIDS worldwide;
7. Remain deeply concerned, however, by the overall expansion and feminization of the pandemic and the fact that women now represent 50 per cent of people living with HIV worldwide and nearly 60 per cent of people living with HIV in Africa, and in this regard recognize that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS;
8. Express grave concern that half of all new HIV infections occur among children and young people under the age of 25, and that there is a lack of information, skills and knowledge regarding HIV/AIDS among young people;

---

1. Resolution S-26/2, annex.

9. Remain gravely concerned that 2.3 million children are living with HIV/AIDS today, and recognize that the lack of paediatric drugs in many countries significantly hinders efforts to protect the health of children;
10. Reiterate with profound concern that the pandemic affects every region, that Africa, in particular sub-Saharan Africa, remains the worst-affected region, and that urgent and exceptional action is required at all levels to curb the devastating effects of this pandemic, and recognize the renewed commitment by African Governments and regional institutions to scale up their own HIV/AIDS responses;
11. Reaffirm that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic, including in the areas of prevention, treatment, care and support, and recognize that addressing stigma and discrimination is also a critical element in combating the global HIV/AIDS pandemic;
12. Reaffirm also that access to medication in the context of pandemics, such as HIV/AIDS, is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
13. Recognize that in many parts of the world, the spread of HIV/AIDS is a cause and consequence of poverty, and that effectively combating HIV/AIDS is essential to the achievement of internationally agreed development goals and objectives, including the Millennium Development Goals;
14. Recognize also that we now have the means to reverse the global pandemic and to avert millions of needless deaths, and that to be effective, we must deliver an intensified, much more urgent and comprehensive response, in partnership with the United Nations system, intergovernmental organizations, people living with HIV and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector, including generic and research-based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders;
15. Recognize further that to mount a comprehensive response, we must overcome any legal, regulatory, trade and other barriers that block access to prevention, treatment, care and support; commit adequate resources; promote and protect all human rights and fundamental freedoms for all; promote gender equality and empowerment of women; promote and protect the rights of the girl child in order to reduce the vulnerability of the girl child to HIV/AIDS; strengthen health systems and support health workers; support greater involvement of people living with HIV; scale up the use of known effective and comprehensive prevention interventions; do everything necessary to ensure access to life-saving drugs and prevention tools; and develop with equal urgency better tools – drugs, diagnostics and prevention technologies, including vaccines and microbicides – for the future;
16. Convinced that without renewed political will, strong leadership and sustained commitment and concerted efforts on the part of all stakeholders at all levels, including

people living with HIV, civil society and vulnerable groups, and without increased resources, the world will not succeed in bringing about the end of the pandemic;

**17.** Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

*Therefore, we:*

**18.** Reaffirm our commitment to implement fully the Declaration of Commitment on HIV/AIDS, entitled “Global Crisis – Global Action”, adopted by the General Assembly at its twenty-sixth special session, in 2001; and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases, the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development;

**19.** Recognize the importance, and encourage the implementation, of the recommendations of the inclusive, country-driven processes and regional consultations facilitated by the Secretariat and the Co-sponsors of the Joint United Nations Programme on HIV/AIDS for scaling up HIV prevention, treatment, care and support, and strongly recommend that this approach be continued;

**20.** Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multi-sectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

**21.** Emphasize the need to strengthen policy and programme linkages and coordination between HIV/AIDS, sexual and reproductive health, national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of HIV/AIDS on national development plans and strategies;

**22.** Reaffirm that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic, and therefore commit ourselves to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use;

expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections;

**23.** Reaffirm also that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the pandemic;

**24.** Commit ourselves to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

**25.** Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status;

**26.** Commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services;

**27.** Commit ourselves also to ensuring that pregnant women have access to antenatal care, information, counselling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counselling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

**28.** Resolve to integrate food and nutritional support, with the goal that all people at all times will have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences, for an active and healthy life, as part of a comprehensive response to HIV/AIDS;

**29.** Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, *inter alia*, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic;

**30.** Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, *inter alia*, sexual and reproductive health, and the provision of full access

to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality;

**31.** Commit ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

**32.** Commit ourselves also to addressing as a priority the vulnerabilities faced by children affected by and living with HIV; providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them;

**33.** Emphasize the need for accelerated scale-up of collaborative activities on tuberculosis and HIV, in line with the Global Plan to Stop TB 2006–2015, and for investment in new drugs, diagnostics and vaccines that are appropriate for people with TB-HIV co-infection;

**34.** Commit ourselves to expanding to the greatest extent possible, supported by international cooperation and partnership, our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems, including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, hepatitis C, sexually transmitted infections, nutrition, children affected, orphaned or made vulnerable by HIV/AIDS, as well as formal and informal education;

**35.** Undertake to reinforce, adopt and implement, where needed, national plans and strategies, supported by international cooperation and partnership, to increase the capacity of human resources for health to meet the urgent need for the training and retention of a broad range of health workers, including community-based health workers; improve training and management and working conditions, including treatment for health workers; and effectively govern the recruitment, retention and deployment of new and existing health workers to mount a more effective HIV/AIDS response;

**36.** Commit ourselves, invite international financial institutions and the Global Fund to Fight AIDS, Tuberculosis and Malaria, according to its policy framework, and encourage other donors, to provide additional resources to low- and middle-

income countries for the strengthening of HIV/AIDS programmes and health systems and for addressing human resources gaps, including the development of alternative and simplified service delivery models and the expansion of the community-level provision of HIV/AIDS prevention, treatment, care and support, as well as other health and social services;

**37.** Reiterate the need for Governments, United Nations agencies, regional and international organizations and non-governmental organizations involved with the provision and delivery of assistance to countries and regions affected by conflicts, humanitarian emergencies or natural disasters to incorporate HIV/AIDS prevention, care and treatment elements into their plans and programmes;

**38.** Pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities;

**39.** Commit ourselves to reducing the global HIV/AIDS resource gap through greater domestic and international funding to enable countries to have access to predictable and sustainable financial resources and ensuring that international funding is aligned with national HIV/AIDS plans and strategies; and in this regard welcome the increased resources that are being made available through bilateral and multilateral initiatives, as well as those that will become available as a result of the establishment of timetables by many developed countries to achieve the targets of 0.7 per cent of gross national product for official development assistance by 2015 and to reach at least 0.5 per cent of gross national product for official development assistance by 2010 as well as, pursuant to the Brussels Programme of Action for the Least Developed Countries for the Decade 2001–2010,<sup>2</sup> 0.15 per cent to 0.20 per cent for the least developed countries no later than 2010, and urge those developed countries that have not yet done so to make concrete efforts in this regard in accordance with their commitments;

**40.** Recognize that the Joint United Nations Programme on HIV/AIDS has estimated that 20 to 23 billion United States dollars per annum is needed by 2010 to support rapidly scaled-up AIDS responses in low- and middle-income countries, and therefore commit ourselves to taking measures to ensure that new and additional resources are made available from donor countries and also from national budgets and other national sources;

**41.** Commit ourselves to supporting and strengthening existing financial mechanisms, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as relevant United Nations organizations, through the provision of funds in a sustained manner, while continuing to develop innovative sources of financing, as well as pursuing other efforts, aimed at generating additional funds;

**42.** Commit ourselves also to finding appropriate solutions to overcome barriers in pricing, tariffs and trade agreements, and to making improvements to legislation,

---

2. A/CONF.191/13, chap. II.

regulatory policy, procurement and supply chain management in order to accelerate and intensify access to affordable and quality HIV/AIDS prevention products, diagnostics, medicines and treatment commodities;

**43.** Reaffirm that the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights does not and should not prevent members from taking measures now and in the future to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement,<sup>3</sup> reaffirm that the Agreement can and should be interpreted and implemented in a manner supportive of the right to protect public health and, in particular, to promote access to medicines for all including the production of generic antiretroviral drugs and other essential drugs for AIDS-related infections. In this connection, we reaffirm the right to use, to the full, the provisions in the TRIPS Agreement, the Doha Declaration on the TRIPS Agreement and Public Health<sup>4</sup> and the World Trade Organization's General Council Decision of 2003<sup>5</sup> and amendments to Article 31, which provide flexibilities for this purpose;

**44.** Resolve to assist developing countries to enable them to employ the flexibilities outlined in the TRIPS Agreement, and to strengthen their capacities for this purpose;

**45.** Commit ourselves to intensifying investment in and efforts towards the research and development of new, safe and affordable HIV/AIDS-related medicines, products and technologies, such as vaccines, female-controlled methods and microbicides, paediatric antiretroviral formulations, including through such mechanisms as Advance Market Commitments, and to encouraging increased investment in HIV/AIDS-related research and development in traditional medicine;

**46.** Encourage pharmaceutical companies, donors, multilateral organizations and other partners to develop public-private partnerships in support of research and development and technology transfer, and in the comprehensive response to HIV/AIDS;

**47.** Encourage bilateral, regional and international efforts to promote bulk procurement, price negotiations and licensing to lower prices for HIV prevention products, diagnostics, medicines and treatment commodities, while recognizing that intellectual property protection is important for the development of new medicines and recognizing the concerns about its effects on prices;

**48.** Recognize the initiative by a group of countries, such as the International Drug Purchase Facility, based on innovative financing mechanisms that aim to provide further drug access at affordable prices to developing countries on a sustainable and predictable basis;

**49.** Commit ourselves to setting, in 2006, through inclusive, transparent processes, ambitious national targets, including interim targets for 2008 in

---

3. See Legal Instruments Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, done at Marrakesh on 15 April 1994 (GATT secretariat publication, Sales No. GATT/1994-7).

4. See World Trade Organization, document WT/MIN(01)/DEC/2. Available at: <http://docsonline.wto.org>.

5. See World Trade Organization, document WT/L/540 and Corr.1. Available at: <http://docsonline.wto.org>.

accordance with the core indicators recommended by the Joint United Nations Programme on HIV/AIDS, that reflect the commitment of the present Declaration and the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010, and to setting up and maintaining sound and rigorous monitoring and evaluation frameworks within their HIV/AIDS strategies;

**50.** Call upon the Joint United Nations Programme on HIV/AIDS, including its Co-sponsors, to assist national efforts to coordinate the AIDS response, as elaborated in the “Three Ones” principles and in line with the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors; assist national and regional efforts to monitor and report on efforts to achieve the targets set out above; and strengthen global coordination on HIV/AIDS, including through the thematic sessions of the Programme Coordinating Board;

**51.** Call upon Governments, national parliaments, donors, regional and subregional organizations, organizations of the United Nations system, the Global Fund to Fight AIDS, Tuberculosis and Malaria, civil society, people living with HIV, vulnerable groups, the private sector, communities most affected by HIV/AIDS and other stakeholders to work closely together to achieve the targets set out above, and to ensure accountability and transparency at all levels through participatory reviews of responses to HIV/AIDS;

**52.** Request the Secretary-General of the United Nations, with the support of the Joint United Nations Programme on HIV/AIDS, to include in his annual report to the General Assembly on the status of implementation of the Declaration of Commitment on HIV/AIDS, in accordance with General Assembly resolution S-26/2 of 27 June 2001, the progress achieved in realizing the commitments set out in the present Declaration;

**53.** Decide to undertake comprehensive reviews in 2008 and 2011, within the annual reviews of the General Assembly, of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS, entitled “Global Crisis – Global Action”, adopted by the General Assembly at its twenty-sixth special session, and the present Declaration.

The UN General Assembly adopted the Political Declaration on HIV/AIDS at its 87th plenary meeting, 2 June 2006. See UN Document A/RES/60/262.

Available online at: [http://data.unaids.org/pub/Report/2006/20060615\\_HLM\\_PoliticalDeclaration\\_ARES60262\\_en.pdf](http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf)

## RESOLUTION ON COMBATING HIV/AIDS

*(World Medical Association, 2006)*

*Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006.*

**mindful** that the WMA Statement on HIV/AIDS and the Medical Profession was adopted at the WMA General Assembly in Pilanesberg, Republic of South Africa, on 14 October 2006; and

**recognising** the alarming statistic from UNAIDS that some 37-38 million people worldwide are infected with HIV, with the number increasing daily, and that 60% percent of them live in sub-Saharan Africa; and

**noting** that there exist evidence-based methods for preventing the spread of the infection and also for life-prolonging treatment; therefore

The WMA urges governments to work closely with health professionals and their representative organizations to identify and implement the critical steps to ensure

1. that all efforts are made to prevent the spread of HIV/AIDS;
2. that the diagnosis, counselling and treatment of patients for HIV/AIDS is undertaken only by appropriately trained physicians and other healthcare personnel, according to established evidence-based principles;
3. that patients be given accurate, relevant and comprehensive information to enable them to make informed decisions about their health care treatment; and
4. that barriers preventing people from coming forward for testing and treatment be identified and eliminated.

The WMA calls on National Medical Associations to use this resolution in their advocacy efforts to their governments, their patients and the public.

Available online at: <http://www.wma.net/e/policy/a24.htm>

## STATEMENT ON HIV/AIDS AND THE MEDICAL PROFESSION

*(World Medical Association, 2006)*

*Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006.*

### INTRODUCTION

1. HIV/AIDS is a global pandemic that has created unprecedented challenges for physicians and health infrastructures. In addition to representing a staggering public health crisis, HIV/AIDS is also fundamentally a human rights issue. Many factors drive the spread of the disease, such as poverty, homelessness, illiteracy, prostitution, human trafficking, stigma, discrimination and gender-based inequality. Efforts to tackle the disease are constrained by the lack of human and financial resources available in health care systems. These social, economic, legal and human rights factors affect not only the public health dimension of HIV/AIDS but also individual physicians/health workers and patients, their decisions and relationships.

### DISCRIMINATION

2. Unfair discrimination against HIV/AIDS patients by physicians must be eliminated completely from the practice of medicine.

- a. All persons infected or affected by HIV/AIDS are entitled to adequate prevention, support, treatment and care with compassion and respect for human dignity.

- b. A physician may not ethically refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.
- c. National Medical Associations should work with governments, patient groups and relevant national and international organizations to ensure that national health policies clearly and explicitly prohibit discrimination against people infected with or affected by HIV/AIDS.

### **APPROPRIATE / COMPETENT MEDICAL CARE**

3. Patients with HIV/AIDS must be provided with competent and appropriate medical care at all stages of the disease.
4. A physician who is not able to provide the care and services required by patients with HIV/AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.
5. Physicians and other appropriate bodies should ensure that patients have accurate information regarding means of transmission of HIV/AIDS and strategies to protect themselves against infection. Proactive measures should be taken to ensure that all members of the population, and at-risk groups in particular, are educated to this effect.
6. With reference to those patients who are found to be seropositive, physicians must be able to effectively counsel them regarding: (a) responsible behaviour to prevent the spread of the disease; (b) strategies for their own health protection; and (c) the necessity of alerting sexual and needle-sharing contacts, past and present, as well as other relevant contacts (such as medical and dental personnel) regarding their possible infection.
7. Physicians must recognize that many people still believe HIV/AIDS to be an automatic and immediate death sentence and therefore will not seek testing. Physicians must ensure that patients have accurate information regarding the treatment options available to them. Patients should understand the potential of antiretroviral treatment (ART) to improve not only their medical condition but also the quality of their lives. Effective ART can greatly extend the period of time that patients are able to lead healthy productive lives, functioning socially and in the workplace and maintaining their independence. HIV/AIDS is increasingly looked upon as a manageable chronic condition.
8. While strongly advocating ART as the best course of action for HIV/AIDS patients, physicians must also ensure that their patients are fully and accurately informed about all aspects of ART, including potential toxicity and side effects. Physicians must also counsel patients honestly about the possibility of failure of first line ART, and the subsequent options should failure occur. The importance of adhering to the regimens and thereby reducing the risk of failure should be emphasized.
9. Physicians should be aware that misinformation regarding the negative aspects of ART has created resistance toward treatment by patients in some areas.

Where misinformation is being spread about ART, physicians and medical associations must make it an immediate priority to publicly challenge the source of the misinformation and to work with the HIV/AIDS community to counteract the negative effects of the misinformation.

**10.** Physicians should encourage the involvement of support networks to assist patients in adhering to ART regimens. With the patient's consent, counselling and training should be available to family members to assist them in providing family based care. Physicians must recognize families and other support networks as crucial partners in adherence strategies and, in many places, the only means to adequately expand the care system so that patients receive the required attention.

**11.** Physicians must be aware of the discriminatory attitudes toward HIV/AIDS that are prevalent in society and local culture. Because physicians are the first, and sometimes the only, people who are informed of their patients' HIV status, physicians should be able to counsel them about their basic social and legal rights and responsibilities or should refer them to counsellors who specialize in the rights of persons living with HIV/AIDS.

### **Testing**

**12.** Mandatory testing for HIV must be required of: donated blood and blood fractions collected for donation or to be used in the manufacture of blood products; organs and other tissues intended for transplantation; and semen or ova collected for assisted reproduction procedures.

**13.** Mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights. Exceptions to this rule may be made only in the most extreme cases and should be subject to review by an ethics panel or to judicial review.

**14.** Physicians must clearly explain the purpose of an HIV test, the reasons it is recommended and the implications of a positive test result. Before a test is administered, the physician should have an action plan in place in case of a positive test result. Informed consent must be obtained from the patient prior to testing.

**15.** While certain groups are labelled "high risk", anyone who has had unprotected sex should be considered at some risk. Physicians must become increasingly proactive about recommending testing to patients, based on a mutual understanding of the level of risk and the potential to benefit from testing. Pregnant women should routinely be offered testing.

**16.** Counselling and voluntary anonymous testing for HIV should be available to all persons who request it, along with adequate post-testing support mechanisms.

### **Protection from HIV in the Health Care Environment**

**17.** Physicians and all health care workers have the right to a safe work environment. Especially in developing countries, the problem of occupational exposure to HIV has contributed to high attrition rates of the health labour force. In some cases, employees become infected with HIV, and in other cases fear of infection causes health care workers to leave their jobs voluntarily. Fear of infection

among health workers can also lead to refusal to treat HIV/AIDS patients. Likewise, patients have the right to be protected to the greatest degree possible from transmission of HIV from health professionals and in health care institutions.

- a. Proper infection control procedures and universal precautions consistent with the most current national or international standards, as appropriate, should be implemented in all health care facilities. This includes procedures for the use of preventive ART for health professionals who have been exposed to HIV.
- b. If the appropriate safeguards for protecting physicians or patients against infection are not in place, physicians and National Medical Associations should take action to correct the situation.
- c. Physicians who are infected with HIV should not engage in any activity that creates a risk of transmission of the disease to others. In the context of possible exposure to HIV, the activity in which the physician wishes to engage will be the determining factor. Whether or not an activity is acceptable should be determined by a panel or committee of health care workers with specific expertise in infectious diseases.
- d. In the provision of medical care, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease.
- e. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose.

### **Protecting Patient Privacy and Issues Related to Notification**

**18.** Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment, to name only a few. Normalizing the presence of HIV/AIDS in society through public education is the only way to reduce discriminatory attitudes and practices. Until that can be universally achieved, or a cure is developed, potentially infected individuals will refuse testing to avoid these consequences. The result of individuals not knowing their HIV status is not only disastrous on a personal level in terms of not receiving treatment, but may also lead to high rates of avoidable transmission of the disease. Fear of unauthorized disclosure of information also provides a disincentive to participate in HIV/AIDS research and generally thwarts the efficacy of prevention programs. Lack of confidence in protection of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injection drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the same health problems of avoidable transmission and delay in treatment.

**19.** All standard ethical principles and duties related to confidentiality and protection of patients' health information, as articulated in the WMA Declaration of Lisbon on the Rights of the Patient, apply equally in the context of HIV/AIDS. In addition, National Medical Associations and physicians should take note of the special circumstances and obligations (outlined below) associated with the treatment of HIV/AIDS patients.

- a.** National Medical Associations and physicians must, as a matter of priority, ensure that HIV/AIDS public education, prevention and counselling programs contain explicit information related to protection of patient information as a matter not only of medical ethics but of their human right to privacy.
- b.** Special safeguards are required when HIV/AIDS care involves a physically dispersed care team that includes home-based service providers, family members, counsellors, case workers or others who require medical information to provide comprehensive care and assist in adherence to treatment regimens. In addition to implementing protection mechanisms regarding transfer of information, ethics training regarding patient privacy should be given to all team members.
- c.** Physicians must make all efforts to convince HIV/AIDS patients to take action to notify all partners (sexual and/or injection drug) about their exposure and potential infection. Physicians must be competent to counsel patients about the options for notifying partners. These options should include:
  - i.** notification of the partner(s) by the patient. In this case, the patient should receive counselling regarding the information that must be provided to the partner and strategies for delivering it with sensitivity and in a manner that is easily understood. A timetable for notification should be established and the physician should follow-up with the patient to ensure that notification has occurred.
  - ii.** notification of the partner(s) by a third party. In this case, the third party must make every effort to protect the identity of the patient.
- d.** When all strategies to convince the patient to take such action have been exhausted, and if the physician knows the identity of the patient's partner(s), the physician is compelled, either by law or by moral obligation, to take action to notify the partner(s) of their potential infection. Depending on the system in place, the physician will either notify directly the person at risk or report the information to a designated authority responsible for notification. In cases where a physician must disclose the information regarding exposure, the physician must:
  - i.** inform the patient of his or her intentions,
  - ii.** to the extent possible, ensure that the identity of the patient is protected,
  - iii.** take the appropriate measures to protect the safety of the patient, especially in the case of a female patient vulnerable to domestic violence.

- e. Regardless of whether it is the patient, the physician or a third party who undertakes notification, the person learning of his or her potential infection should be offered support and assistance in order to access testing and treatment.
- f. National Medical Associations should develop guidelines to assist physicians in decision-making related to notification. These guidelines should help physicians understand the legal requirements and consequences of notification decisions as well as the medical, psychological, social and ethical considerations.
- g. National Medical Associations should work with governments to ensure that physicians who carry out their ethical obligation to notify individuals at risk, and who take precautions to protect the identity of their patient, are afforded adequate legal protection.

### **Medical Education**

- 20. National Medical Associations should assist in ensuring that there is training and education of physicians in the most current prevention strategies and medical treatments available for all stages of HIV/AIDS, including prevention and support.
- 21. National Medical Associations should insist upon, and assist with when possible, the education of physicians in the relevant psychological, legal, cultural and social dimensions of HIV/AIDS.
- 22. National Medical Associations should fully support the efforts of physicians wishing to concentrate their expertise in HIV/AIDS care, even where HIV/AIDS is not recognized as an official specialty or sub-specialty within the medical education system.
- 23. The WMA encourages its National Medical Associations to promote the inclusion of designated, comprehensive courses on HIV/AIDS in undergraduate and postgraduate medical education programs, as well as continuing medical education.

Available online at: <http://www.wma.net/e/policy/a25.htm>

# 14/HUMAN RIGHTS (GENERAL)

- Vienna Declaration and Programme of Action (World Conference on Human Rights, 1993)
- London Declaration (Amnesty International, 1995)
- Position Statement on Nurses and Human Rights (International Council of Nurses, 1998)

## VIENNA DECLARATION AND PROGRAMME OF ACTION

*(World Conference on Human Rights, 1993)*

### I

**1.** The World Conference on Human Rights reaffirms the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law. The universal nature of these rights and freedoms is beyond question.

In this framework, enhancement of international cooperation in the field of human rights is essential for the full achievement of the purposes of the United Nations.

Human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments.

**2.** All peoples have the right of self-determination. By virtue of that right they freely determine their political status, and freely pursue their economic, social and cultural development.

Taking into account the particular situation of peoples under colonial or other forms of alien domination or foreign occupation, the World Conference on Human Rights recognizes the right of peoples to take any legitimate action, in accordance with the Charter of the United Nations, to realize their inalienable right of self-determination. The World Conference on Human Rights considers the denial of the right of self-determination as a violation of human rights and underlines the importance of the effective realization of this right.

In accordance with the Declaration on Principles of International Law concerning Friendly Relations and Cooperation Among States in accordance with the Charter of the United Nations, this shall not be construed as authorizing or encouraging any action which would dismember or impair, totally or in part, the territorial integrity or political unity of sovereign and independent States conducting themselves in compliance with the principle of equal rights and self-determination

of peoples and thus possessed of a Government representing the whole people belonging to the territory without distinction of any kind.

**3.** Effective international measures to guarantee and monitor the implementation of human rights standards should be taken in respect of people under foreign occupation, and effective legal protection against the violation of their human rights should be provided, in accordance with human rights norms and international law, particularly the Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 14 August 1949, and other applicable norms of humanitarian law.

**4.** The promotion and protection of all human rights and fundamental freedoms must be considered as a priority objective of the United Nations in accordance with its purposes and principles, in particular the purpose of international cooperation. In the framework of these purposes and principles, the promotion and protection of all human rights is a legitimate concern of the international community. The organs and specialized agencies related to human rights should therefore further enhance the coordination of their activities based on the consistent and objective application of international human rights instruments.

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

**6.** The efforts of the United Nations system towards the universal respect for, and observance of, human rights and fundamental freedoms for all, contribute to the stability and well-being necessary for peaceful and friendly relations among nations, and to improved conditions for peace and security as well as social and economic development, in conformity with the Charter of the United Nations.

**7.** The processes of promoting and protecting human rights should be conducted in conformity with the purposes and principles of the Charter of the United Nations, and international law.

**8.** Democracy, development and respect for human rights and fundamental freedoms are interdependent and mutually reinforcing. Democracy is based on the freely expressed will of the people to determine their own political, economic, social and cultural systems and their full participation in all aspects of their lives. In the context of the above, the promotion and protection of human rights and fundamental freedoms at the national and international levels should be universal and conducted without conditions attached. The international community should support the strengthening and promoting of democracy, development and respect for human rights and fundamental freedoms in the entire world.

**9.** The World Conference on Human Rights reaffirms that least developed countries committed to the process of democratization and economic reforms, many

of which are in Africa, should be supported by the international community in order to succeed in their transition to democracy and economic development.

**10.** The World Conference on Human Rights reaffirms the right to development, as established in the Declaration on the Right to Development, as a universal and inalienable right and an integral part of fundamental human rights.

As stated in the Declaration on the Right to Development, the human person is the central subject of development.

While development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights.

States should cooperate with each other in ensuring development and eliminating obstacles to development. The international community should promote an effective international cooperation for the realization of the right to development and the elimination of obstacles to development.

Lasting progress towards the implementation of the right to development requires effective development policies at the national level, as well as equitable economic relations and a favourable economic environment at the international level.

**11.** The right to development should be fulfilled so as to meet equitably the developmental and environmental needs of present and future generations. The World Conference on Human Rights recognizes that illicit dumping of toxic and dangerous substances and waste potentially constitutes a serious threat to the human rights to life and health of everyone.

Consequently, the World Conference on Human Rights calls on all States to adopt and vigorously implement existing conventions relating to the dumping of toxic and dangerous products and waste and to cooperate in the prevention of illicit dumping.

Everyone has the right to enjoy the benefits of scientific progress and its applications. The World Conference on Human Rights notes that certain advances, notably in the biomedical and life sciences as well as in information technology, may have potentially adverse consequences for the integrity, dignity and human rights of the individual, and calls for international cooperation to ensure that human rights and dignity are fully respected in this area of universal concern.

**12.** The World Conference on Human Rights calls upon the international community to make all efforts to help alleviate the external debt burden of developing countries, in order to supplement the efforts of the Governments of such countries to attain the full realization of the economic, social and cultural rights of their people.

**13.** There is a need for States and international organizations, in cooperation with non-governmental organizations, to create favourable conditions at the national, regional and international levels to ensure the full and effective enjoyment of human rights. States should eliminate all violations of human rights and their causes, as well as obstacles to the enjoyment of these rights.

**14.** The existence of widespread extreme poverty inhibits the full and effective enjoyment of human rights; its immediate alleviation and eventual elimination must remain a high priority for the international community.

**15.** Respect for human rights and for fundamental freedoms without distinction of any kind is a fundamental rule of international human rights law. The speedy and comprehensive elimination of all forms of racism and racial discrimination, xenophobia and related intolerance is a priority task for the international community. Governments should take effective measures to prevent and combat them. Groups, institutions, intergovernmental and non-governmental organizations and individuals are urged to intensify their efforts in cooperating and coordinating their activities against these evils.

**16.** The World Conference on Human Rights welcomes the progress made in dismantling apartheid and calls upon the international community and the United Nations system to assist in this process.

The World Conference on Human Rights also deplores the continuing acts of violence aimed at undermining the quest for a peaceful dismantling of apartheid.

**17.** The acts, methods and practices of terrorism in all its forms and manifestations as well as linkage in some countries to drug trafficking are activities aimed at the destruction of human rights, fundamental freedoms and democracy, threatening territorial integrity, security of States and destabilizing legitimately constituted Governments. The international community should take the necessary steps to enhance cooperation to prevent and combat terrorism.

**18.** The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.

Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support.

The human rights of women should form an integral part of the United Nations human rights activities, including the promotion of all human rights instruments relating to women.

The World Conference on Human Rights urges Governments, institutions, intergovernmental and non-governmental organizations to intensify their efforts for the protection and promotion of human rights of women and the girl-child.

**19.** Considering the importance of the promotion and protection of the rights of persons belonging to minorities and the contribution of such promotion and protection to the political and social stability of the States in which such persons live,

The World Conference on Human Rights reaffirms the obligation of States to ensure that persons belonging to minorities may exercise fully and effectively all human rights and fundamental freedoms without any discrimination and in full equality before the law in accordance with the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities.

The persons belonging to minorities have the right to enjoy their own culture, to profess and practise their own religion and to use their own language in private and in public, freely and without interference or any form of discrimination.

**20.** The World Conference on Human Rights recognizes the inherent dignity and the unique contribution of indigenous people to the development and plurality of society and strongly reaffirms the commitment of the international community to their economic, social and cultural well-being and their enjoyment of the fruits of sustainable development. States should ensure the full and free participation of indigenous people in all aspects of society, in particular in matters of concern to them. Considering the importance of the promotion and protection of the rights of indigenous people, and the contribution of such promotion and protection to the political and social stability of the States in which such people live, States should, in accordance with international law, take concerted positive steps to ensure respect for all human rights and fundamental freedoms of indigenous people, on the basis of equality and non-discrimination, and recognize the value and diversity of their distinct identities, cultures and social organization.

**21.** The World Conference on Human Rights, welcoming the early ratification of the Convention on the Rights of the Child by a large number of States and noting the recognition of the human rights of children in the World Declaration on the Survival, Protection and Development of Children and Plan of Action adopted by the World Summit for Children, urges universal ratification of the Convention by 1995 and its effective implementation by States parties through the adoption of all the necessary legislative, administrative and other measures and the allocation to the maximum extent of the available resources. In all actions concerning children, non-discrimination and the best interest of the child should be primary considerations and the views of the child given due weight. National and international mechanisms and programmes should be strengthened for the defence and protection of children, in particular, the girl-child, abandoned children, street children, economically and sexually exploited children, including through child pornography, child prostitution or sale of organs, children victims of diseases including acquired immunodeficiency syndrome, refugee and displaced children, children in detention, children in armed conflict, as well as children victims of famine and drought and other emergencies. International cooperation and solidarity should be promoted to support the implementation of the Convention and the rights of the child should be a priority in the United Nations system-wide action on human rights.

The World Conference on Human Rights also stresses that the child for the full and harmonious development of his or her personality should grow up in a family environment which accordingly merits broader protection.

**22.** Special attention needs to be paid to ensuring non-discrimination and the equal enjoyment of all human rights and fundamental freedoms by disabled persons, including their active participation in all aspects of society.

**23.** The World Conference on Human Rights reaffirms that everyone, without distinction of any kind, is entitled to the right to seek and to enjoy in other countries

asylum from persecution, as well as the right to return to one's own country. In this respect it stresses the importance of the Universal Declaration of Human Rights, the 1951 Convention relating to the Status of Refugees, its 1967 Protocol and regional instruments. It expresses its appreciation to States that continue to admit and host large numbers of refugees in their territories, and to the Office of the United Nations High Commissioner for Refugees for its dedication to its task. It also expresses its appreciation to the United Nations Relief and Works Agency for Palestine Refugees in the Near East.

The World Conference on Human Rights recognizes that gross violations of human rights, including in armed conflicts, are among the multiple and complex factors leading to displacement of people.

The World Conference on Human Rights recognizes that, in view of the complexities of the global refugee crisis and in accordance with the Charter of the United Nations, relevant international instruments and international solidarity and in the spirit of burden-sharing, a comprehensive approach by the international community is needed in coordination and cooperation with the countries concerned and relevant organizations, bearing in mind the mandate of the United Nations High Commissioner for Refugees. This should include the development of strategies to address the root causes and effects of movements of refugees and other displaced persons, the strengthening of emergency preparedness and response mechanisms, the provision of effective protection and assistance, bearing in mind the special needs of women and children, as well as the achievement of durable solutions, primarily through the preferred solution of dignified and safe voluntary repatriation, including solutions such as those adopted by the international refugee conferences. The World Conference on Human Rights underlines the responsibilities of States, particularly as they relate to the countries of origin.

In the light of the comprehensive approach, the World Conference on Human Rights emphasizes the importance of giving special attention including through intergovernmental and humanitarian organizations and finding lasting solutions to questions related to internally displaced persons including their voluntary and safe return and rehabilitation.

In accordance with the Charter of the United Nations and the principles of humanitarian law, the World Conference on Human Rights further emphasizes the importance of and the need for humanitarian assistance to victims of all natural and man-made disasters.

**24.** Great importance must be given to the promotion and protection of the human rights of persons belonging to groups which have been rendered vulnerable, including migrant workers, the elimination of all forms of discrimination against them, and the strengthening and more effective implementation of existing human rights instruments. States have an obligation to create and maintain adequate measures at the national level, in particular in the fields of education, health and social support, for the promotion and protection of the rights of persons in vulnerable sectors of their populations and to ensure the participation of those among them who are interested in finding a solution to their own problems.

**25.** The World Conference on Human Rights affirms that extreme poverty and social exclusion constitute a violation of human dignity and that urgent steps are necessary to achieve better knowledge of extreme poverty and its causes, including those related to the problem of development, in order to promote the human rights of the poorest, and to put an end to extreme poverty and social exclusion and to promote the enjoyment of the fruits of social progress. It is essential for States to foster participation by the poorest people in the decision-making process by the community in which they live, the promotion of human rights and efforts to combat extreme poverty.

**26.** The World Conference on Human Rights welcomes the progress made in the codification of human rights instruments, which is a dynamic and evolving process, and urges the universal ratification of human rights treaties. All States are encouraged to accede to these international instruments; all States are encouraged to avoid, as far as possible, the resort to reservations.

**27.** Every State should provide an effective framework of remedies to redress human rights grievances or violations. The administration of justice, including law enforcement and prosecutorial agencies and, especially, an independent judiciary and legal profession in full conformity with applicable standards contained in international human rights instruments, are essential to the full and non-discriminatory realization of human rights and indispensable to the processes of democracy and sustainable development. In this context, institutions concerned with the administration of justice should be properly funded, and an increased level of both technical and financial assistance should be provided by the international community. It is incumbent upon the United Nations to make use of special programmes of advisory services on a priority basis for the achievement of a strong and independent administration of justice.

**28.** The World Conference on Human Rights expresses its dismay at massive violations of human rights especially in the form of genocide, “ethnic cleansing” and systematic rape of women in war situations, creating mass exodus of refugees and displaced persons. While strongly condemning such abhorrent practices it reiterates the call that perpetrators of such crimes be punished and such practices immediately stopped.

**29.** The World Conference on Human Rights expresses grave concern about continuing human rights violations in all parts of the world in disregard of standards as contained in international human rights instruments and international humanitarian law and about the lack of sufficient and effective remedies for the victims.

The World Conference on Human Rights is deeply concerned about violations of human rights during armed conflicts, affecting the civilian population, especially women, children, the elderly and the disabled. The Conference therefore calls upon States and all parties to armed conflicts strictly to observe international humanitarian law, as set forth in the Geneva Conventions of 1949 and other rules and principles of international law, as well as minimum standards for protection of human rights, as laid down in international conventions.

The World Conference on Human Rights reaffirms the right of the victims to be assisted by humanitarian organizations, as set forth in the Geneva Conventions of 1949 and other relevant instruments of international humanitarian law, and calls for the safe and timely access for such assistance.

**30.** The World Conference on Human Rights also expresses its dismay and condemnation that gross and systematic violations and situations that constitute serious obstacles to the full enjoyment of all human rights continue to occur in different parts of the world. Such violations and obstacles include, as well as torture and cruel, inhuman and degrading treatment or punishment, summary and arbitrary executions, disappearances, arbitrary detentions, all forms of racism, racial discrimination and apartheid, foreign occupation and alien domination, xenophobia, poverty, hunger and other denials of economic, social and cultural rights, religious intolerance, terrorism, discrimination against women and lack of the rule of law.

**31.** The World Conference on Human Rights calls upon States to refrain from any unilateral measure not in accordance with international law and the Charter of the United Nations that creates obstacles to trade relations among States and impedes the full realization of the human rights set forth in the Universal Declaration of Human Rights and international human rights instruments, in particular the rights of everyone to a standard of living adequate for their health and well-being, including food and medical care, housing and the necessary social services. The World Conference on Human Rights affirms that food should not be used as a tool for political pressure.

**32.** The World Conference on Human Rights reaffirms the importance of ensuring the universality, objectivity and non-selectivity of the consideration of human rights issues.

**33.** The World Conference on Human Rights reaffirms that States are duty-bound, as stipulated in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights and in other international human rights instruments, to ensure that education is aimed at strengthening the respect of human rights and fundamental freedoms. The World Conference on Human Rights emphasizes the importance of incorporating the subject of human rights education programmes and calls upon States to do so. Education should promote understanding, tolerance, peace and friendly relations between the nations and all racial or religious groups and encourage the development of United Nations activities in pursuance of these objectives. Therefore, education on human rights and the dissemination of proper information, both theoretical and practical, play an important role in the promotion and respect of human rights with regard to all individuals without distinction of any kind such as race, sex, language or religion, and this should be integrated in the education policies at the national as well as international levels. The World Conference on Human Rights notes that resource constraints and institutional inadequacies may impede the immediate realization of these objectives.

**34.** Increased efforts should be made to assist countries which so request to create the conditions whereby each individual can enjoy universal human rights

and fundamental freedoms. Governments, the United Nations system as well as other multilateral organizations are urged to increase considerably the resources allocated to programmes aiming at the establishment and strengthening of national legislation, national institutions and related infrastructures which uphold the rule of law and democracy, electoral assistance, human rights awareness through training, teaching and education, popular participation and civil society.

The programmes of advisory services and technical cooperation under the Centre for Human Rights should be strengthened as well as made more efficient and transparent and thus become a major contribution to improving respect for human rights. States are called upon to increase their contributions to these programmes, both through promoting a larger allocation from the United Nations regular budget, and through voluntary contributions.

**35.** The full and effective implementation of United Nations activities to promote and protect human rights must reflect the high importance accorded to human rights by the Charter of the United Nations and the demands of the United Nations human rights activities, as mandated by Member States. To this end, United Nations human rights activities should be provided with increased resources.

**36.** The World Conference on Human Rights reaffirms the important and constructive role played by national institutions for the promotion and protection of human rights, in particular in their advisory capacity to the competent authorities, their role in remedying human rights violations, in the dissemination of human rights information, and education in human rights.

The World Conference on Human Rights encourages the establishment and strengthening of national institutions, having regard to the “Principles relating to the status of national institutions” and recognizing that it is the right of each State to choose the framework which is best suited to its particular needs at the national level.

**37.** Regional arrangements play a fundamental role in promoting and protecting human rights. They should reinforce universal human rights standards, as contained in international human rights instruments, and their protection. The World Conference on Human Rights endorses efforts under way to strengthen these arrangements and to increase their effectiveness, while at the same time stressing the importance of cooperation with the United Nations human rights activities.

The World Conference on Human Rights reiterates the need to consider the possibility of establishing regional and sub-regional arrangements for the promotion and protection of human rights where they do not already exist.

**38.** The World Conference on Human Rights recognizes the important role of non-governmental organizations in the promotion of all human rights and in humanitarian activities at national, regional and international levels. The World Conference on Human Rights appreciates their contribution to increasing public awareness of human rights issues, to the conduct of education, training and research in this field, and to the promotion and protection of all human rights and fundamental freedoms. While recognizing that the primary responsibility for standard-setting lies with States, the conference also appreciates the contribution

of non-governmental organizations to this process. In this respect, the World Conference on Human Rights emphasizes the importance of continued dialogue and cooperation between Governments and non-governmental organizations. Non-governmental organizations and their members genuinely involved in the field of human rights should enjoy the rights and freedoms recognized in the Universal Declaration of Human Rights, and the protection of the national law. These rights and freedoms may not be exercised contrary to the purposes and principles of the United Nations. Non-governmental organizations should be free to carry out their human rights activities, without interference, within the framework of national law and the Universal Declaration of Human Rights.

**39.** Underlining the importance of objective, responsible and impartial information about human rights and humanitarian issues, the World Conference on Human Rights encourages the increased involvement of the media, for whom freedom and protection should be guaranteed within the framework of national law.

## **II**

### **A. INCREASED COORDINATION ON HUMAN RIGHTS WITHIN THE UNITED NATIONS SYSTEM**

**1.** The World Conference on Human Rights recommends increased coordination in support of human rights and fundamental freedoms within the United Nations system. To this end, the World Conference on Human Rights urges all United Nations organs, bodies and the specialized agencies whose activities deal with human rights to cooperate in order to strengthen, rationalize and streamline their activities, taking into account the need to avoid unnecessary duplication. The World Conference on Human Rights also recommends to the Secretary-General that high-level officials of relevant United Nations bodies and specialized agencies at their annual meeting, besides coordinating their activities, also assess the impact of their strategies and policies on the enjoyment of all human rights.

**2.** Furthermore, the World Conference on Human Rights calls on regional organizations and prominent international and regional finance and development institutions to assess also the impact of their policies and programmes on the enjoyment of human rights.

**3.** The World Conference on Human Rights recognizes that relevant specialized agencies and bodies and institutions of the United Nations system as well as other relevant intergovernmental organizations whose activities deal with human rights play a vital role in the formulation, promotion and implementation of human rights standards, within their respective mandates, and should take into account the outcome of the World Conference on Human Rights within their fields of competence.

**4.** The World Conference on Human Rights strongly recommends that a concerted effort be made to encourage and facilitate the ratification of and accession or succession to international human rights treaties and protocols adopted within the framework of the United Nations system with the aim of universal acceptance. The Secretary-General, in consultation with treaty bodies, should

consider opening a dialogue with States not having acceded to these human rights treaties, in order to identify obstacles and to seek ways of overcoming them.

**5.** The World Conference on Human Rights encourages States to consider limiting the extent of any reservations they lodge to international human rights instruments, formulate any reservations as precisely and narrowly as possible, ensure that none is incompatible with the object and purpose of the relevant treaty and regularly review any reservations with a view to withdrawing them.

**6.** The World Conference on Human Rights, recognizing the need to maintain consistency with the high quality of existing international standards and to avoid proliferation of human rights instruments, reaffirms the guidelines relating to the elaboration of new international instruments contained in General Assembly resolution 41/120 of 4 December 1986 and calls on the United Nations human rights bodies, when considering the elaboration of new international standards, to keep those guidelines in mind, to consult with human rights treaty bodies on the necessity for drafting new standards and to request the Secretariat to carry out technical reviews of proposed new instruments.

**7.** The World Conference on Human Rights recommends that human rights officers be assigned if and when necessary to regional offices of the United Nations Organization with the purpose of disseminating information and offering training and other technical assistance in the field of human rights upon the request of concerned Member States. Human rights training for international civil servants who are assigned to work relating to human rights should be organized.

**8.** The World Conference on Human Rights welcomes the convening of emergency sessions of the Commission on Human Rights as a positive initiative and that other ways of responding to acute violations of human rights be considered by the relevant organs of the United Nations system.

### **Resources**

**9.** The World Conference on Human Rights, concerned by the growing disparity between the activities of the Centre for Human Rights and the human, financial and other resources available to carry them out, and bearing in mind the resources needed for other important United Nations programmes, requests the Secretary-General and the General Assembly to take immediate steps to increase substantially the resources for the human rights programme from within the existing and future regular budgets of the United Nations, and to take urgent steps to seek increased extra-budgetary resources.

**10.** Within this framework, an increased proportion of the regular budget should be allocated directly to the Centre for Human Rights to cover its costs and all other costs borne by the Centre for Human Rights, including those related to the United Nations human rights bodies. Voluntary funding of the Centre's technical cooperation activities should reinforce this enhanced budget; the World Conference on Human Rights calls for generous contributions to the existing trust funds.

**11.** The World Conference on Human Rights requests the Secretary-General and the General Assembly to provide sufficient human, financial and other resources to

the Centre for Human Rights to enable it effectively, efficiently and expeditiously to carry out its activities.

**12.** The World Conference on Human Rights, noting the need to ensure that human and financial resources are available to carry out the human rights activities, as mandated by intergovernmental bodies, urges the Secretary-General, in accordance with Article 101 of the Charter of the United Nations, and Member States to adopt a coherent approach aimed at securing that resources commensurate to the increased mandates are allocated to the Secretariat. The World Conference on Human Rights invites the Secretary-General to consider whether adjustments to procedures in the programme budget cycle would be necessary or helpful to ensure the timely and effective implementation of human rights activities as mandated by Member States.

### **Centre for Human Rights**

**13.** The World Conference on Human Rights stresses the importance of strengthening the United Nations Centre for Human Rights.

**14.** The Centre for Human Rights should play an important role in coordinating system-wide attention for human rights. The focal role of the Centre can best be realized if it is enabled to cooperate fully with other United Nations bodies and organs. The coordinating role of the Centre for Human Rights also implies that the office of the Centre for Human Rights in New York is strengthened.

**15.** The Centre for Human Rights should be assured adequate means for the system of thematic and country rapporteurs, experts, working groups and treaty bodies. Follow-up on recommendations should become a priority matter for consideration by the Commission on Human Rights.

**16.** The Centre for Human Rights should assume a larger role in the promotion of human rights. This role could be given shape through cooperation with Member States and by an enhanced programme of advisory services and technical assistance. The existing voluntary funds will have to be expanded substantially for these purposes and should be managed in a more efficient and coordinated way. All activities should follow strict and transparent project management rules and regular programme and project evaluations should be held periodically. To this end, the results of such evaluation exercises and other relevant information should be made available regularly. The Centre should, in particular, organize at least once a year information meetings open to all Member States and organizations directly involved in these projects and programmes.

### **Adaptation and strengthening of the United Nations machinery for human rights, including the question of the establishment of United Nations High Commissioner for Human Rights**

**17.** The World Conference on Human Rights recognizes the necessity for a continuing adaptation of the United Nations human rights machinery to the current and future needs in the promotion and protection of human rights, as reflected in

the present Declaration and within the framework of a balanced and sustainable development for all people. In particular, the United Nations human rights organs should improve their coordination, efficiency and effectiveness.

**18.** The World Conference on Human Rights recommends to the General Assembly that when examining the report of the Conference at its forty-eighth session, it begin, as a matter of priority, consideration of the question of the establishment of a High Commissioner for Human Rights for the promotion and protection of all human rights.

## **B. EQUALITY, DIGNITY AND TOLERANCE**

### **1. Racism, racial discrimination, xenophobia and other forms of intolerance**

**19.** The World Conference on Human Rights considers the elimination of racism and racial discrimination, in particular in their institutionalized forms such as apartheid or resulting from doctrines of racial superiority or exclusivity or contemporary forms and manifestations of racism, as a primary objective for the international community and a worldwide promotion programme in the field of human rights. United Nations organs and agencies should strengthen their efforts to implement such a programme of action related to the third decade to combat racism and racial discrimination as well as subsequent mandates to the same end. The World Conference on Human Rights strongly appeals to the international community to contribute generously to the Trust Fund for the Programme for the Decade for Action to Combat Racism and Racial Discrimination.

**20.** The World Conference on Human Rights urges all Governments to take immediate measures and to develop strong policies to prevent and combat all forms and manifestations of racism, xenophobia or related intolerance, where necessary by enactment of appropriate legislation, including penal measures, and by the establishment of national institutions to combat such phenomena.

**21.** The World Conference on Human Rights welcomes the decision of the Commission on Human Rights to appoint a Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance. The World Conference on Human Rights also appeals to all States parties to the International Convention on the Elimination of All Forms of Racial Discrimination to consider making the declaration under article 14 of the Convention.

**22.** The World Conference on Human Rights calls upon all Governments to take all appropriate measures in compliance with their international obligations and with due regard to their respective legal systems to counter intolerance and related violence based on religion or belief, including practices of discrimination against women and including the desecration of religious sites, recognizing that every individual has the right to freedom of thought, conscience, expression and religion. The Conference also invites all States to put into practice the provisions of the Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief.

**23.** The World Conference on Human Rights stresses that all persons who perpetrate or authorize criminal acts associated with ethnic cleansing are

individually responsible and accountable for such human rights violations, and that the international community should exert every effort to bring those legally responsible for such violations to justice.

**24.** The World Conference on Human Rights calls on all States to take immediate measures, individually and collectively, to combat the practice of ethnic cleansing to bring it quickly to an end. Victims of the abhorrent practice of ethnic cleansing are entitled to appropriate and effective remedies.

## **2. Persons belonging to national or ethnic, religious and linguistic minorities**

**25.** The World Conference on Human Rights calls on the Commission on Human Rights to examine ways and means to promote and protect effectively the rights of persons belonging to minorities as set out in the Declaration on the Rights of Persons belonging to National or Ethnic, Religious and Linguistic Minorities. In this context, the World Conference on Human Rights calls upon the Centre for Human Rights to provide, at the request of Governments concerned and as part of its programme of advisory services and technical assistance, qualified expertise on minority issues and human rights, as well as on the prevention and resolution of disputes, to assist in existing or potential situations involving minorities.

**26.** The World Conference on Human Rights urges States and the international community to promote and protect the rights of persons belonging to national or ethnic, religious and linguistic minorities in accordance with the Declaration on the Rights of Persons belonging to National or Ethnic, Religious and Linguistic Minorities.

**27.** Measures to be taken, where appropriate, should include facilitation of their full participation in all aspects of the political, economic, social, religious and cultural life of society and in the economic progress and development in their country.

### ***Indigenous people***

**28.** The World Conference on Human Rights calls on the Working Group on Indigenous Populations of the Sub-Commission on Prevention of Discrimination and Protection of Minorities to complete the drafting of a declaration on the rights of indigenous people at its eleventh session.

**29.** The World Conference on Human Rights recommends that the Commission on Human Rights consider the renewal and updating of the mandate of the Working Group on Indigenous Populations upon completion of the drafting of a declaration on the rights of indigenous people.

**30.** The World Conference on Human Rights also recommends that advisory services and technical assistance programmes within the United Nations system respond positively to requests by States for assistance which would be of direct benefit to indigenous people. The World Conference on Human Rights further recommends that adequate human and financial resources be made available to the Centre for Human Rights within the overall framework of strengthening the Centre's activities as envisaged by this document.

**31.** The World Conference on Human Rights urges States to ensure the full and free participation of indigenous people in all aspects of society, in particular in matters of concern to them.

**32.** The World Conference on Human Rights recommends that the General Assembly proclaim an international decade of the world's indigenous people, to begin from January 1994, including action-orientated programmes, to be decided upon in partnership with indigenous people. An appropriate voluntary trust fund should be set up for this purpose. In the framework of such a decade, the establishment of a permanent forum for indigenous people in the United Nations system should be considered.

### ***Migrant workers***

**33.** The World Conference on Human Rights urges all States to guarantee the protection of the human rights of all migrant workers and their families.

**34.** The World Conference on Human Rights considers that the creation of conditions to foster greater harmony and tolerance between migrant workers and the rest of the society of the State in which they reside is of particular importance.

**35.** The World Conference on Human Rights invites States to consider the possibility of signing and ratifying, at the earliest possible time, the International Convention on the Rights of All Migrant Workers and Members of Their Families.

### **3. THE EQUAL STATUS AND HUMAN RIGHTS OF WOMEN**

**36.** The World Conference on Human Rights urges the full and equal enjoyment by women of all human rights and that this be a priority for Governments and for the United Nations. The World Conference on Human Rights also underlines the importance of the integration and full participation of women as both agents and beneficiaries in the development process, and reiterates the objectives established on global action for women towards sustainable and equitable development set forth in the Rio Declaration on Environment and Development and chapter 24 of Agenda 21, adopted by the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 3–14 June 1992).

**37.** The equal status of women and the human rights of women should be integrated into the mainstream of United Nations system-wide activity. These issues should be regularly and systematically addressed throughout relevant United Nations bodies and mechanisms. In particular, steps should be taken to increase cooperation and promote further integration of objectives and goals between the Commission on the Status of Women, the Commission on Human Rights, the Committee for the Elimination of Discrimination against Women, the United Nations Development Fund for Women, the United Nations Development Programme and other United Nations agencies. In this context, cooperation and coordination should be strengthened between the Centre for Human Rights and the Division for the Advancement of Women.

**38.** In particular, the World Conference on Human Rights stresses the importance of working towards the elimination of violence against women in public and private life, the elimination of all forms of sexual harassment, exploitation and trafficking in women, the elimination of gender bias in the administration of justice and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism. The World Conference on Human Rights calls upon the General Assembly to adopt the draft declaration on violence against women and urges States to combat violence against women in accordance with its provisions. Violations of the human rights of women in situations of armed conflict are violations of the fundamental principles of international human rights and humanitarian law. All violations of this kind, including in particular murder, systematic rape, sexual slavery, and forced pregnancy, require a particularly effective response.

**39.** The World Conference on Human Rights urges the eradication of all forms of discrimination against women, both hidden and overt. The United Nations should encourage the goal of universal ratification by all States of the Convention on the Elimination of All Forms of Discrimination against Women by the year 2000. Ways and means of addressing the particularly large number of reservations to the Convention should be encouraged. *Inter alia*, the Committee on the Elimination of Discrimination against Women should continue its review of reservations to the Convention. States are urged to withdraw reservations that are contrary to the object and purpose of the Convention or which are otherwise incompatible with international treaty law.

**40.** Treaty monitoring bodies should disseminate necessary information to enable women to make more effective use of existing implementation procedures in their pursuits of full and equal enjoyment of human rights and non-discrimination. New procedures should also be adopted to strengthen implementation of the commitment to women's equality and the human rights of women. The Commission on the Status of Women and the Committee on the Elimination of Discrimination against Women should quickly examine the possibility of introducing the right of petition through the preparation of an optional protocol to the Convention on the Elimination of All Forms of Discrimination against Women. The World Conference on Human Rights welcomes the decision of the Commission on Human Rights to consider the appointment of a special rapporteur on violence against women at its fiftieth session.

**41.** The World Conference on Human Rights recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span. In the context of the World Conference on Women and the Convention on the Elimination of All Forms of Discrimination against Women, as well as the Proclamation of Tehran of 1968, the World Conference on Human Rights reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.

**42.** Treaty monitoring bodies should include the status of women and the human rights of women in their deliberations and findings, making use of gender-specific data. States should be encouraged to supply information on the situation of women *de jure* and *de facto* in their reports to treaty monitoring bodies. The World Conference on Human Rights notes with satisfaction that the Commission on Human Rights adopted at its forty-ninth session resolution 1993/46 of 8 March 1993 stating that rapporteurs and working groups in the field of human rights should also be encouraged to do so. Steps should also be taken by the Division for the Advancement of Women in cooperation with other United Nations bodies, specifically the Centre for Human Rights, to ensure that the human rights activities of the United Nations regularly address violations of women's human rights, including gender-specific abuses. Training for United Nations human rights and humanitarian relief personnel to assist them to recognize and deal with human rights abuses particular to women and to carry out their work without gender bias should be encouraged.

**43.** The World Conference on Human Rights urges Governments and regional and international organizations to facilitate the access of women to decision-making posts and their greater participation in the decision-making process. It encourages further steps within the United Nations Secretariat to appoint and promote women staff members in accordance with the Charter of the United Nations, and encourages other principal and subsidiary organs of the United Nations to guarantee the participation of women under conditions of equality.

**44.** The World Conference on Human Rights welcomes the World Conference on Women to be held in Beijing in 1995 and urges that human rights of women should play an important role in its deliberations, in accordance with the priority themes of the World Conference on Women of equality, development and peace.

#### **4. THE RIGHTS OF THE CHILD**

**45.** The World Conference on Human Rights reiterates the principle of "First Call for Children" and, in this respect, underlines the importance of major national and international efforts, especially those of the United Nations Children's Fund, for promoting respect for the rights of the child to survival, protection, development and participation.

**46.** Measures should be taken to achieve universal ratification of the Convention on the Rights of the Child by 1995 and the universal signing of the World Declaration on the Survival, Protection and Development of Children and Plan of Action adopted by the World Summit for Children, as well as their effective implementation. The World Conference on Human Rights urges States to withdraw reservations to the Convention on the Rights of the Child contrary to the object and purpose of the Convention or otherwise contrary to international treaty law.

**47.** The World Conference on Human Rights urges all nations to undertake measures to the maximum extent of their available resources, with the support of international cooperation, to achieve the goals in the World Summit Plan of Action.

The Conference calls on States to integrate the Convention on the Rights of the Child into their national action plans. By means of these national action plans and through international efforts, particular priority should be placed on reducing infant and maternal mortality rates, reducing malnutrition and illiteracy rates and providing access to safe drinking water and to basic education. Whenever so called for, national plans of action should be devised to combat devastating emergencies resulting from natural disasters and armed conflicts and the equally grave problem of children in extreme poverty.

**48.** The World Conference on Human Rights urges all States, with the support of international cooperation, to address the acute problem of children under especially difficult circumstances. Exploitation and abuse of children should be actively combated, including by addressing their root causes. Effective measures are required against female infanticide, harmful child labour, sale of children and organs, child prostitution, child pornography, as well as other forms of sexual abuse.

**49.** The World Conference on Human Rights supports all measures by the United Nations and its specialized agencies to ensure the effective protection and promotion of human rights of the girl child. The World Conference on Human Rights urges States to repeal existing laws and regulations and remove customs and practices which discriminate against and cause harm to the girl child.

**50.** The World Conference on Human Rights strongly supports the proposal that the Secretary-General initiate a study into means of improving the protection of children in armed conflicts. Humanitarian norms should be implemented and measures taken in order to protect and facilitate assistance to children in war zones. Measures should include protection for children against indiscriminate use of all weapons of war, especially anti-personnel mines. The need for aftercare and rehabilitation of children traumatized by war must be addressed urgently. The Conference calls on the Committee on the Rights of the Child to study the question of raising the minimum age of recruitment into armed forces.

**51.** The World Conference on Human Rights recommends that matters relating to human rights and the situation of children be regularly reviewed and monitored by all relevant organs and mechanisms of the United Nations system and by the supervisory bodies of the specialized agencies in accordance with their mandates.

**52.** The World Conference on Human Rights recognizes the important role played by non-governmental organizations in the effective implementation of all human rights instruments and, in particular, the Convention on the Rights of the Child.

**53.** The World Conference on Human Rights recommends that the Committee on the Rights of the Child, with the assistance of the Centre for Human Rights, be enabled expeditiously and effectively to meet its mandate, especially in view of the unprecedented extent of ratification and subsequent submission of country reports.

## **5. FREEDOM FROM TORTURE**

**54.** The World Conference on Human Rights welcomes the ratification by many Member States of the Convention against Torture and Other Cruel, Inhuman or

Degrading Treatment or Punishment and encourages its speedy ratification by all other Member States.

**55.** The World Conference on Human Rights emphasizes that one of the most atrocious violations against human dignity is the act of torture, the result of which destroys the dignity and impairs the capability of victims to continue their lives and their activities.

**56.** The World Conference on Human Rights reaffirms that under human rights law and international humanitarian law, freedom from torture is a right which must be protected under all circumstances, including in times of internal or international disturbance or armed conflicts.

**57.** The World Conference on Human Rights therefore urges all States to put an immediate end to the practice of torture and eradicate this evil forever through full implementation of the Universal Declaration of Human Rights as well as the relevant conventions and, where necessary, strengthening of existing mechanisms. The World Conference on Human Rights calls on all States to cooperate fully with the Special Rapporteur on the question of torture in the fulfilment of his mandate.

**58.** Special attention should be given to ensure universal respect for, and effective implementation of, the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment adopted by the General Assembly of the United Nations.

**59.** The World Conference on Human Rights stresses the importance of further concrete action within the framework of the United Nations with the view to providing assistance to victims of torture and ensure more effective remedies for their physical, psychological and social rehabilitation. Providing the necessary resources for this purpose should be given high priority, *inter alia*, by additional contributions to the United Nations Voluntary Fund for the Victims of Torture.

**60.** States should abrogate legislation leading to impunity for those responsible for grave violations of human rights such as torture and prosecute such violations, thereby providing a firm basis for the rule of law.

**61.** The World Conference on Human Rights reaffirms that efforts to eradicate torture should, first and foremost, be concentrated on prevention and, therefore, calls for the early adoption of an optional protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, which is intended to establish a preventive system of regular visits to places of detention.

### **Enforced disappearances**

**62.** The World Conference on Human Rights, welcoming the adoption by the General Assembly of the Declaration on the Protection of All Persons from Enforced Disappearance, calls upon all States to take effective legislative, administrative, judicial or other measures to prevent, terminate and punish acts of enforced disappearances. The World Conference on Human Rights reaffirms that it is the duty of all States, under any circumstances, to make investigations whenever there

is reason to believe that an enforced disappearance has taken place on a territory under their jurisdiction and, if allegations are confirmed, to prosecute its perpetrators.

## **6. THE RIGHTS OF THE DISABLED PERSON**

**63.** The World Conference on Human Rights reaffirms that all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities. Every person is born equal and has the same rights to life and welfare, education and work, living independently and active participation in all aspects of society. Any direct discrimination or other negative discriminatory treatment of a disabled person is therefore a violation of his or her rights. The World Conference on Human Rights calls on Governments, where necessary, to adopt or adjust legislation to assure access to these and other rights for disabled persons.

**64.** The place of disabled persons is everywhere. Persons with disabilities should be guaranteed equal opportunity through the elimination of all socially determined barriers, be they physical, financial, social or psychological, which exclude or restrict full participation in society.

**65.** Recalling the World Programme of Action concerning Disabled Persons, adopted by the General Assembly at its thirty-seventh session, the World Conference on Human Rights calls upon the General Assembly and the Economic and Social Council to adopt the draft standard rules on the equalization of opportunities for persons with disabilities, at their meetings in 1993.

## **C. COOPERATION, DEVELOPMENT AND STRENGTHENING OF HUMAN RIGHTS**

**66.** The World Conference on Human Rights recommends that priority be given to national and international action to promote democracy, development and human rights.

**67.** Special emphasis should be given to measures to assist in the strengthening and building of institutions relating to human rights, strengthening of a pluralistic civil society and the protection of groups which have been rendered vulnerable. In this context, assistance provided upon the request of Governments for the conduct of free and fair elections, including assistance in the human rights aspects of elections and public information about elections, is of particular importance. Equally important is the assistance to be given to the strengthening of the rule of law, the promotion of freedom of expression and the administration of justice, and to the real and effective participation of the people in the decision-making processes.

**68.** The World Conference on Human Rights stresses the need for the implementation of strengthened advisory services and technical assistance activities by the Centre for Human Rights. The Centre should make available to States upon request assistance on specific human rights issues, including the preparation of reports under human rights treaties as well as for the implementation of coherent and comprehensive plans of action for the promotion and protection of human rights. Strengthening the institutions of human rights and democracy, the legal protection of human rights, training of officials and others, broad-based education

and public information aimed at promoting respect for human rights should all be available as components of these programmes.

**69.** The World Conference on Human Rights strongly recommends that a comprehensive programme be established within the United Nations in order to help States in the task of building and strengthening adequate national structures which have a direct impact on the overall observance of human rights and the maintenance of the rule of law. Such a programme, to be coordinated by the Centre for Human Rights, should be able to provide, upon the request of the interested Government, technical and financial assistance to national projects in reforming penal and correctional establishments, education and training of lawyers, judges and security forces in human rights, and any other sphere of activity relevant to the good functioning of the rule of law. That programme should make available to States assistance for the implementation of plans of action for the promotion and protection of human rights.

**70.** The World Conference on Human Rights requests the Secretary-General of the United Nations to submit proposals to the United Nations General Assembly, containing alternatives for the establishment, structure, operational modalities and funding of the proposed programme.

**71.** The World Conference on Human Rights recommends that each State consider the desirability of drawing up a national action plan identifying steps whereby that State would improve the promotion and protection of human rights.

**72.** The World Conference on Human Rights on Human Rights reaffirms that the universal and inalienable right to development, as established in the Declaration on the Right to Development, must be implemented and realized. In this context, the World Conference on Human Rights welcomes the appointment by the Commission on Human Rights of a thematic working group on the right to development and urges that the Working Group, in consultation and cooperation with other organs and agencies of the United Nations system, promptly formulate, for early consideration by the United Nations General Assembly, comprehensive and effective measures to eliminate obstacles to the implementation and realization of the Declaration on the Right to Development and recommending ways and means towards the realization of the right to development by all States.

**73.** The World Conference on Human Rights recommends that non-governmental and other grass-roots organizations active in development and/or human rights should be enabled to play a major role on the national and international levels in the debate, activities and implementation relating to the right to development and, in cooperation with Governments, in all relevant aspects of development cooperation.

**74.** The World Conference on Human Rights appeals to Governments, competent agencies and institutions to increase considerably the resources devoted to building well-functioning legal systems able to protect human rights, and to national institutions working in this area. Actors in the field of development cooperation should bear in mind the mutually reinforcing interrelationship between development, democracy and human rights. Cooperation should be based on

dialogue and transparency. The World Conference on Human Rights also calls for the establishment of comprehensive programmes, including resource banks of information and personnel with expertise relating to the strengthening of the rule of law and of democratic institutions.

**75.** The World Conference on Human Rights encourages the Commission on Human Rights, in cooperation with the Committee on Economic, Social and Cultural Rights, to continue the examination of optional protocols to the International Covenant on Economic, Social and Cultural Rights.

**76.** The World Conference on Human Rights recommends that more resources be made available for the strengthening or the establishment of regional arrangements for the promotion and protection of human rights under the programmes of advisory services and technical assistance of the Centre for Human Rights. States are encouraged to request assistance for such purposes as regional and sub-regional workshops, seminars and information exchanges designed to strengthen regional arrangements for the promotion and protection of human rights in accord with universal human rights standards as contained in international human rights instruments.

**77.** The World Conference on Human Rights supports all measures by the United Nations and its relevant specialized agencies to ensure the effective promotion and protection of trade union rights, as stipulated in the International Covenant on Economic, Social and Cultural Rights and other relevant international instruments. It calls on all States to abide fully by their obligations in this regard contained in international instruments.

#### **D. HUMAN RIGHTS EDUCATION**

**78.** The World Conference on Human Rights considers human rights education, training and public information essential for the promotion and achievement of stable and harmonious relations among communities and for fostering mutual understanding, tolerance and peace.

**79.** States should strive to eradicate illiteracy and should direct education towards the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. The World Conference on Human Rights calls on all States and institutions to include human rights, humanitarian law, democracy and rule of law as subjects in the curricula of all learning institutions in formal and non-formal settings.

**80.** Human rights education should include peace, democracy, development and social justice, as set forth in international and regional human rights instruments, in order to achieve common understanding and awareness with a view to strengthening universal commitment to human rights.

**81.** Taking into account the World Plan of Action on Education for Human Rights and Democracy, adopted in March 1993 by the International Congress on Education for Human Rights and Democracy of the United Nations Educational, Scientific and Cultural Organization, and other human rights instruments, the World Conference on Human Rights recommends that States develop specific

programmes and strategies for ensuring the widest human rights education and the dissemination of public information, taking particular account of the human rights needs of women.

**82.** Governments, with the assistance of intergovernmental organizations, national institutions and non-governmental organizations, should promote an increased awareness of human rights and mutual tolerance. The World Conference on Human Rights underlines the importance of strengthening the World Public Information Campaign for Human Rights carried out by the United Nations. They should initiate and support education in human rights and undertake effective dissemination of public information in this field. The advisory services and technical assistance programmes of the United Nations system should be able to respond immediately to requests from States for educational and training activities in the field of human rights as well as for special education concerning standards as contained in international human rights instruments and in humanitarian law and their application to special groups such as military forces, law enforcement personnel, police and the health profession. The proclamation of a United Nations decade for human rights education in order to promote, encourage and focus these educational activities should be considered.

#### **E. IMPLEMENTATION AND MONITORING METHODS**

**83.** The World Conference on Human Rights urges Governments to incorporate standards as contained in international human rights instruments in domestic legislation and to strengthen national structures, institutions and organs of society which play a role in promoting and safeguarding human rights.

**84.** The World Conference on Human Rights recommends the strengthening of United Nations activities and programmes to meet requests for assistance by States which want to establish or strengthen their own national institutions for the promotion and protection of human rights.

**85.** The World Conference on Human Rights also encourages the strengthening of cooperation between national institutions for the promotion and protection of human rights, particularly through exchanges of information and experience, as well as cooperation with regional organizations and the United Nations.

**86.** The World Conference on Human Rights strongly recommends in this regard that representatives of national institutions for the promotion and protection of human rights convene periodic meetings under the auspices of the Centre for Human Rights to examine ways and means of improving their mechanisms and sharing experiences.

**87.** The World Conference on Human Rights recommends to the human rights treaty bodies, to the meetings of chairpersons of the treaty bodies and to the meetings of States parties that they continue to take steps aimed at coordinating the multiple reporting requirements and guidelines for preparing State reports under the respective human rights conventions and study the suggestion that the

submission of one overall report on treaty obligations undertaken by each State would make these procedures more effective and increase their impact.

**88.** The World Conference on Human Rights recommends that the States parties to international human rights instruments, the General Assembly and the Economic and Social Council should consider studying the existing human rights treaty bodies and the various thematic mechanisms and procedures with a view to promoting greater efficiency and effectiveness through better coordination of the various bodies, mechanisms and procedures, taking into account the need to avoid unnecessary duplication and overlapping of their mandates and tasks.

**89.** The World Conference on Human Rights recommends continued work on the improvement of the functioning, including the monitoring tasks, of the treaty bodies, taking into account multiple proposals made in this respect, in particular those made by the treaty bodies themselves and by the meetings of the chairpersons of the treaty bodies. The comprehensive national approach taken by the Committee on the Rights of the Child should also be encouraged.

**90.** The World Conference on Human Rights recommends that States parties to human rights treaties consider accepting all the available optional communication procedures.

**91.** The World Conference on Human Rights views with concern the issue of impunity of perpetrators of human rights violations, and supports the efforts of the Commission on Human Rights and the Sub-Commission on Prevention of Discrimination and Protection of Minorities to examine all aspects of the issue.

**92.** The World Conference on Human Rights recommends that the Commission on Human Rights examine the possibility for better implementation of existing human rights instruments at the international and regional levels and encourages the International Law Commission to continue its work on an international criminal court.

**93.** The World Conference on Human Rights appeals to States which have not yet done so to accede to the Geneva Conventions of 12 August 1949 and the Protocols thereto, and to take all appropriate national measures, including legislative ones, for their full implementation.

**94.** The World Conference on Human Rights recommends the speedy completion and adoption of the draft declaration on the right and responsibility of individuals, groups and organs of society to promote and protect universally recognized human rights and fundamental freedoms.

**95.** The World Conference on Human Rights underlines the importance of preserving and strengthening the system of special procedures, rapporteurs, representatives, experts and working groups of the Commission on Human Rights and the Sub-Commission on the Prevention of Discrimination and Protection of Minorities, in order to enable them to carry out their mandates in all countries throughout the world, providing them with the necessary human and financial resources. The procedures and mechanisms should be enabled to harmonize and rationalize their work through periodic meetings. All States are asked to cooperate fully with these procedures and mechanisms.

**96.** The World Conference on Human Rights recommends that the United Nations assume a more active role in the promotion and protection of human rights in ensuring full respect for international humanitarian law in all situations of armed conflict, in accordance with the purposes and principles of the Charter of the United Nations.

**97.** The World Conference on Human Rights, recognizing the important role of human rights components in specific arrangements concerning some peace-keeping operations by the United Nations, recommends that the Secretary-General take into account the reporting, experience and capabilities of the Centre for Human Rights and human rights mechanisms, in conformity with the Charter of the United Nations.

**98.** To strengthen the enjoyment of economic, social and cultural rights, additional approaches should be examined, such as a system of indicators to measure progress in the realization of the rights set forth in the International Covenant on Economic, Social and Cultural Rights. There must be a concerted effort to ensure recognition of economic, social and cultural rights at the national, regional and international levels.

#### **F. FOLLOW-UP TO THE WORLD CONFERENCE ON HUMAN RIGHTS**

**99.** The World Conference on Human Rights on Human Rights recommends that the General Assembly, the Commission on Human Rights and other organs and agencies of the United Nations system related to human rights consider ways and means for the full implementation, without delay, of the recommendations contained in the present Declaration, including the possibility of proclaiming a United Nations decade for human rights. The World Conference on Human Rights further recommends that the Commission on Human Rights annually review the progress towards this end.

**100.** The World Conference on Human Rights requests the Secretary-General of the United Nations to invite on the occasion of the fiftieth anniversary of the Universal Declaration of Human Rights all States, all organs and agencies of the United Nations system related to human rights, to report to him on the progress made in the implementation of the present Declaration and to submit a report to the General Assembly at its fifty-third session, through the Commission on Human Rights and the Economic and Social Council. Likewise, regional and, as appropriate, national human rights institutions, as well as non-governmental organizations, may present their views to the Secretary-General on the progress made in the implementation of the present Declaration. Special attention should be paid to assessing the progress towards the goal of universal ratification of international human rights treaties and protocols adopted within the framework of the United Nations system.

World Conference on Human Rights, Vienna, 14-25 June 1993: Vienna Declaration and Programme of Action. UN Document A/CONF.157/23, 12 July 1993

Available online at:

[http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En)

## LONDON DECLARATION

*(Amnesty International, 1995)*

On the occasion of the 21st anniversary of the establishment of the first Amnesty International medical group, this meeting of representatives of the Amnesty International Health Professionals Network, which consists of physicians, nurses, psychologists, dentists, students in the health professions and others with a special commitment to health and human rights throughout the world:

**believing that** health professionals should defend and promote human rights as an inherent part of their activities to promote health and well-being,

**reaffirms** its commitment to the application of health care skills, knowledge and ethics to the defence and promotion of human rights around the world, in particular to:

- free all prisoners of conscience
- ensure fair and prompt trials for political prisoners
- abolish the death penalty, torture and other cruel, inhuman or degrading treatment or punishment
- end the denial of medical care as a form of ill-treatment
- end extrajudicial executions and “disappearances”;

**calls on** all health professionals to apply their clinical skills and professional ethics to the prevention of human rights violations and the defence of humane values;

**urges** professional associations and societies to undertake systematic activities to defend those under threat of human rights violations and to investigate and act upon all reports of human rights abuses by health professionals;

**invites** all health professionals to join with the Network, either as members of Amnesty International or independently, to work to achieve these objectives.

Available online at: <http://web.amnesty.org/pages/health-ethicslondon-eng>

## POSITION STATEMENT ON NURSES AND HUMAN RIGHTS

*(International Council of Nurses, 1998)*

The International Council of Nurses adopted a position on The Nurse’s Role in the Safeguarding of Human Rights in 1983; the statement was revised in 1993 and then replaced by the following position statement in 1998, which was revised in 2006.

### ICN POSITION

Human rights in health care involve both recipients and providers. The International Council of Nurses (ICN) views health care as a right of all individuals, regardless of financial, political, geographic, racial or religious considerations. This right includes the right to choose or decline care, including the right to accept or refuse treatment or nourishment; informed consent; confidentiality, and dignity, including the right to die with dignity. It involves both the rights of those seeking care and the providers.

## **HUMAN RIGHTS AND THE NURSE'S ROLE**

Nurses have an obligation to safeguard and actively promote people's health rights at all times and in all places. This includes assuring that adequate care is provided within the resources available and in accordance with nursing ethics. As well, the nurse is obliged to ensure that patients receive appropriate information in understandable language prior to consenting to treatment or procedures, including participation in research.

Nurses are accountable for their own actions and inactions in safeguarding human rights, while National Nurses Associations (NNAs) have a responsibility to participate in the development of health and social legislation related to patient rights.

Where nurses face a "dual loyalty" involving conflict between their professional duties and their obligations to their employer or other authority, the nurse's primary responsibility is to those who require care.

## **NURSES' RIGHTS**

Nurses have the right to practice in accordance with the nursing legislation of the country in which they work and to adopt the ICN Code of Ethics for Nurses or their own national ethical code. They also have a right to practice in an environment that provides personal safety, freedom from abuse and violence, threats or intimidation.

Nurses individually and collectively through their national nurses associations have a duty to speak up when there are violations of human rights, particularly those related to access to essential health care and patient safety.

National nurses' associations need to ensure an effective mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with difficult human rights situations.

## **BACKGROUND**

Nurses deal with human rights issues daily, in all aspects of their professional role. As such, they may be pressured to apply their knowledge and skills in ways that are detrimental to patients and others. There is a need for increased vigilance, and a requirement to be well informed, about how new technology and experimentation can violate human rights. Furthermore nurses are increasingly facing complex human rights issues, arising from conflict situations within jurisdictions, political upheaval and wars. The application of human rights protection should emphasise vulnerable groups such as women, children, elderly, refugees and stigmatised groups. To prepare nurses to adequately address human rights, human rights issues and the nurses' role need to be included in all levels of nursing education programmes.

ICN endorses the Universal Declaration of Human Rights [1] and ICN addresses human rights issues through a number of mechanisms including advocacy and lobbying, position statements, fact sheets, and other means.

[1] Universal Declaration of Human Rights (1948), New York: United Nations. (Replaces previous ICN Position: The Nurse's Role in Safeguarding Human Rights, adopted 1983, updated 1993).

Available online at: <http://www.icn.ch/pshumrights.htm>

# 15/HUNGER STRIKES

- Declaration of Malta on Hunger Strikers (World Medical Association, 1991, last revised 2006)

## DECLARATION OF MALTA ON HUNGER STRIKERS

*(World Medical Association, 1991, 1992, 2006)*

*Adopted by the 43rd World Medical Assembly Malta, November 1991 and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.*

### PREAMBLE

**1.** Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are often a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term or feigned food refusals rarely raise ethical problems. Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences. These guidelines and the background paper address such difficult situations.

### PRINCIPLES

**2.** Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.

3. **Respect for autonomy.** Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.
4. **'Benefit' and 'harm'.** Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or 'primum non nocere'. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.
5. **Balancing dual loyalties.** Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.
6. **Clinical independence.** Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.
7. **Confidentiality.** The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.
8. **Gaining trust.** Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

### **Guidelines for the Management of Hunger Strikers**

Since the medical profession considers the principle of sanctity of life to be fundamental to its practice, the following practical guidelines are recommended for doctors who treat hunger strikers:

9. **Physicians must assess individuals' mental capacity.** This involves verifying that an individual intending to fast does not have a mental impairment that would

seriously undermine the person's ability to make health care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.

**10.** As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.

**11.** A thorough examination of the hunger striker should be made at the start of the fast. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.

**12.** Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.

**13.** Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.

**14.** Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.

**15.** If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.

**16.** Continuing communication between physician and hunger strikers is critical. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. These findings must be appropriately recorded.

**17.** When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.

**18.** If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.

**19.** Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.

**20.** Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.

**21.** Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

Available online at: <http://www.wma.net/e/policy/h31.htm>

# 16/MENTAL ILLNESS

- Declaration on the Rights of Mentally Retarded Persons (United Nations, 1971)
- Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991)
- Statement on Ethical Issues Concerning Patients with Mental Illness (World Medical Association, 1995, last revised 2006)
- Mental Health Care Law: Ten Basic Principles (World Health Organization, 1996)

## DECLARATION ON THE RIGHTS OF MENTALLY RETARDED PERSONS

*(United Nations, 1971)*

### THE GENERAL ASSEMBLY,

**Mindful** of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

**Reaffirming** faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

**Recalling** the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

**Emphasizing** that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

**Bearing** in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

**Aware** that certain countries, at their present stage of development, can devote only limited efforts to this end,

**Proclaims** this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.
2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.
3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.
4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.
5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.
6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.
7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971

Available online at: [http://www.unhchr.ch/html/menu3/b/m\\_mental.htm](http://www.unhchr.ch/html/menu3/b/m_mental.htm)

## PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND THE IMPROVEMENT OF MENTAL HEALTH CARE

*(United Nations, 1991)*

### APPLICATION

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

### DEFINITIONS

In these Principles:

“**counsel**” means a legal or other qualified representative;

**“independent authority”** means a competent and independent authority prescribed by domestic law;

**“mental health care”** includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

**“mental health facility”** means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

**“mental health practitioner”** means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

**“patient”** means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

**“personal representative”** means a person charged by law with the duty of representing a patient’s interests in any specified respect or of exercising specified rights on the patient’s behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

**“the review body”** means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

## **GENERAL LIMITATION CLAUSE**

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

### **Principle 1. Fundamental Freedoms and Basic Rights**

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. “Discrimination” means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of

Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

**6.** Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is in issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

**7.** Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

### **Principle 2. Protection of Minors**

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

### **Principle 3. Life in the Community**

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

### **Principle 4. Determination of Mental Illness**

**1.** A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

**2.** A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.

**3.** Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.

4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.

5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

**Principle 5. Medical Examination**

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

**Principle 6. Confidentiality**

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

**Principle 7. Role of Community and Culture**

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.

2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

3. Every patient shall have the right to treatment suited to his or her cultural background.

**Principle 8. Standards of Care**

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

**Principle 9. Treatment**

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted

standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

**Principle 10. Medication**

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment, or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

**Principle 11. Consent to Treatment**

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely without threats or improper inducements after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

- a. The diagnostic assessment;
- b. The purpose, method, likely duration and expected benefit of the proposed treatment;
- c. Alternative modes of treatment, including those less intrusive; and
- d. Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

- a. The patient is, at the relevant time, held as an involuntary patient;
- b. An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic

legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

**c.** The independent authority is satisfied that the proposed plan of treatment is in the best interests of the patient's health needs.

**7.** Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

**8.** Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

**9.** Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

**10.** All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

**11.** Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them, and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

**12.** Sterilization shall never be carried out as a treatment for mental illness.

**13.** A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

**14.** Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility; and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given

informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

**15.** Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment but only with the approval of a competent, independent review body specifically constituted for this purpose.

**16.** In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

### **Principle 12. Notice of Rights**

**1.** A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.

**2.** If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

**3.** A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf as well as a person to represent his or her interests to the authorities of the facility.

### **Principle 13. Rights and Conditions in Mental Health Facilities**

**1.** Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

- a.** Recognition everywhere as a person before the law;
- b.** Privacy;
- c.** Freedom of communication which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
- d.** Freedom of religion or belief.

**2.** The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

- a.** Facilities for recreational and leisure activities;
- b.** Facilities for education;

- c. Facilities to purchase or receive items for daily living, recreation and communication;
  - d. Facilities, and encouragement to use such facilities, for a patient's engagement in an active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.
3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.
  4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall in any event have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

#### **Principle 14. Resources for Mental Health Facilities**

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
  - a. Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
  - b. Diagnostic and therapeutic equipment for the patient;
  - c. Appropriate professional care; and
  - d. Adequate, regular and comprehensive treatment, including supplies of medication.
2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment, and care of patients comply with these Principles.

#### **Principle 15. Admission Principles**

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.
2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

#### **Principle 16. Involuntary Admission**

1. A person may (a) be admitted involuntarily to a mental health facility as a

patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that that person has a mental illness and considers:

- a. That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
- b. That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.
3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

### **Principle 17. Review Body**

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.
2. The review body's initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.
3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.
4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.
5. At each review the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.

6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

#### **Principle 18. Procedural Safeguards**

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.

6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

7. Any decision whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the

need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

**Principle 19. Access to Information**

1. A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.
2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

**Principle 20. Criminal Offender**

1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.
2. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.
3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.
4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.

**Principle 21. Complaints**

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

**Principle 22. Monitoring and Remedies**

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

**Principle 23. Implementation**

1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures which they shall review periodically.
2. States shall make these Principles widely known by appropriate and active means.

**Principle 24. Scope of Principles Relating to Mental Health Facilities**

These Principles apply to all persons who are admitted to a mental health facility.

**Principle 25. Saving of Existing Rights**

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent.

Available online at: <http://www.unhchr.ch/html/menu3/b/68.htm>

## STATEMENT ON ETHICAL ISSUES CONCERNING PATIENTS WITH MENTAL ILLNESS

*(World Medical Association, 1995, 2006)*

*Adopted by the 47th WMA General Assembly, Bali, Indonesia, September 1995 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.*

**PREAMBLE**

1. Historically, many societies have regarded patients with mental illness as a threat to those around them rather than as people in need of support and care. Therefore, in the absence of effective treatment, many patients with mental illness were confined to asylums for all or part of their lives. The aim of such confinement in these cases was to prevent behaviour that was self-destructive or aggressive toward others.
2. At the present time, progress in psychiatric therapy allows for better care of patients with mental illness. Efficacious drugs and other treatments can result in patient outcomes ranging from complete alleviation of symptoms to long remissions for patients whose conditions are more serious.
3. Patients with mental illness should be viewed, treated and granted the same access to care as any other medical patient. However, this is often not enough since patients with mental illnesses may not know when to seek treatment for somatic problems. Therefore, the physician should actively refer these patients to other physicians when necessary.
4. A physician has the same obligations toward patients with mental illness as toward any other patient.
5. The physician's primary role as healer of patients must not be undermined by serving as the agent of the greater society, except in instances of danger to the public.

**6.** Recognition must be given to the fact that a large proportion of patients with mental illness are treated by physicians who are not psychiatrists. The same ethical obligations and limitations would apply to these physicians.

### **ETHICAL PRINCIPLES**

**7.** The discrimination associated with psychiatry and the mentally ill should be eliminated. This stigma often discourages people in need from seeking psychiatric help, thereby aggravating their situation and placing them at risk of emotional or physical harm.

**8.** The physician aspires for a therapeutic relationship founded on mutual trust. He/she should inform the patient of the nature of the patient's condition, standard therapeutic procedures (including possible alternatives and the risk of each), and the expected outcomes for the available therapeutic choices.

**9.** In the absence of legally adjudicated incompetence, psychiatric patients must be dealt with as though they are legally competent. The patient's judgment should be respected in areas where he/she is legally capable of making decisions, unless they present a risk of serious harm to themselves or others. A patient with mental illness who is incapable of legally exercising his/her autonomy should be treated like any other patient who is temporarily or permanently legally incompetent. If the patient lacks the capacity to make a decision as to his/her medical care, surrogate consent should be sought from an authorized representative in accordance with applicable law.

**10.** Involuntary hospitalization of psychiatric patients evokes ethical controversy. While laws regarding involuntary hospitalization and treatment vary worldwide, it is generally acknowledged that this treatment decision requires the following: (a) a severe mental disorder that prevents the individual from making his/her own treatment decisions; and/or (b) the likelihood that the patient may harm him/herself or others. Physicians should consider compulsory hospitalization to be exceptional and should utilize it only when it is medically necessary and for the shortest duration feasible under the circumstances.

**11.** Every physician should offer the patient the best available therapy to his/her knowledge, and should treat the patient with the solicitude and respect due all human beings. The physician practising in a psychiatric institution, the military or a prison can be faced with a conflict between his/her responsibilities to society and the responsibilities to the patient. The physician's primary loyalty and duty must be to the patient's best interest. The physician should ensure that the patient is made aware of the conflict in order to minimize feelings of betrayal, and should offer the patient the opportunity to understand measures mandated by legal authority.

**12.** The confidentiality and privacy of all patients should be safeguarded. When required by law, the physician should disclose only the required relevant material and should disclose such material only to the entity having legal authority to make such a request or demand. Data banks that allow access to or transfer of information from one authority to another may be used provided that medical confidentiality is respected and such access or transfer is fully compliant with applicable law.

**13.** A physician must never use his/her professional position to violate the dignity or human rights of any individual or group and should never allow his/her personal desires, needs, feelings, prejudices or beliefs to interfere with the treatment. Neither should a physician take advantage of his/her professional position or the vulnerability of a patient to abuse his/her authority.

### **RECOMMENDATION**

**14.** National Medical Associations should publicize this Statement and use it as a basis for affirming the ethical foundations for treatment of patients with mental illness.

Available online at: <http://www.wma.net/e/policy/e11.htm>

## **MENTAL HEALTH CARE LAW: TEN BASIC PRINCIPLES**

*(World Health Organization, 1996)*

### **1. PROMOTION OF MENTAL HEALTH AND PREVENTION OF MENTAL DISORDERS**

#### **Description**

Everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders.

#### **Components**

This principle includes the following components:

- 1.** Mental health promotion efforts;
- 2.** Mental disorders prevention efforts.

#### **Implementation**

Selected actions suggested to promote this principle include:

- 1.** Promoting behaviours which contribute to enhancing and maintaining mental well-being.
- 2.** Identifying and taking appropriate actions to eliminate the causes of mental disorders.

### **2. ACCESS TO BASIC MENTAL HEALTH CARE**

#### **Description**

Everyone in need should have access to basic mental health care.

#### **Components**

This principle includes the following components:

- 1.** Mental health care should be of adequate quality, i.e.
  - a.** preserve the dignity of the patient;
  - b.** take into consideration and allow for techniques which help patients to cope by themselves with their mental health impairments, disabilities and handicaps;
  - c.** provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of the patient;

- d. maintain a mental health care system of adequate quality (including primary health care, outpatient, inpatient and residential facilities);
- 2. Access to mental health care should be affordable and equitable;
- 3. Mental health care should be geographically accessible;
- 4. Mental health care should be available on a voluntary basis, as health care in general;
- 5. Access to health care, including mental health care, is contingent upon the available human and logistical resources.

### **Implementation**

Selected actions suggested to promote this principle are:

- 1. Having a specific provision in the law which guarantees quality health care, preferably a general provision on health care applying to mental health by extension;
- 2. Having medical practices in keeping with quality assurance guidelines such as those developed by WHO;
- 3. Having developed and/or adapted at national level quality assurance guidelines and instruments by and for all qualified professionals or governmental bodies;
- 4. Offering mental health care which is culturally appropriate;
- 5. Calling for and taking into consideration the patient's assessment of the quality of care;
- 6. Having treatments, decisions and measures regarding a person to whom mental health care is provided, documented in the person's medical record;
- 7. Introducing a mental health component into Primary Health Care;
- 8. Promoting health insurance programs (public or private) offering coverage to the widest possible number of individuals and which do not exclude but specifically include mental health care;
- 9. Having a voluntary admission procedure incorporated into the mental health law scheme which is abided by in practice;
- 10. Having mental health care geographically "accessible" according to WHO's indications, i.e.:
  - a. by making basic mental health care available within one hour walking or travelling distance; and
  - b. by making available the essential drugs identified by WHO (or drugs of the same family
  - c. with similar properties: amitriptyline, biperiden, carbamazepine, chlorpromazine,
  - d. clomipramine, diazepam, fenobarbitone, fluphenazine decanoate, haloperidol, imipramine, lithium carbonate and temazepam).

## **3. MENTAL HEALTH ASSESSMENTS IN ACCORDANCE WITH INTERNATIONALLY ACCEPTED PRINCIPLES**

### **Description**

Mental health assessments should be made in accordance with internationally accepted medical principles and instruments (e.g.: WHO's ICD-10 Classification of

Mental and Behavioural Disorders – Clinical Descriptions and Diagnostic Guidelines, Tenth Revision, 1992).

### **Components**

This principle includes the following components:

1. Mental health assessments include:
  - a. diagnosis;
  - b. choice of a treatment;
  - c. determination of competence;
  - d. determination that someone may cause harm to self or others due to a mental disorder;
2. Mental health assessments should only be conducted for purposes directly relating to mental illness or the consequences of mental illness.

### **Implementation**

Selected actions suggested to promote this principle are:

1. Promoting clinical training in the use of internationally accepted principles;
2. Refraining from referring to non-clinical criteria, such as political, economic, social, racial and religious grounds when assessing potential to cause harm to self or others;
3. Performing complete reassessments each time a new assessment is conducted;
4. Refraining from basing an assessment only on past medical history of mental disorder.

## **4. PROVISION OF THE LEAST RESTRICTIVE TYPE OF MENTAL HEALTH CARE**

### **Description**

Persons with mental health disorders should be provided with health care which is the least restrictive.

### **Components**

This principle includes the following components:

1. Items to be considered in the selection of least restrictive alternatives include:
  - a. the disorder involved;
  - b. the available treatments;
  - c. the person's level of autonomy;
  - d. the person's acceptance and cooperation; and
  - e. the potential that harm be caused to self or others;
2. Community-based treatment should be made available to qualifying patients;
3. Institution-based treatments should be provided in the least restrictive environment and treatments involving the use of physical (e.g. isolation rooms, camisoles) and chemical restraints, if at all necessary, should be contingent upon:
  - a. sustained attempts to discuss alternatives with the patient;
  - b. examination and prescription by an approved health care provider;
  - c. the necessity to avoid immediate harm to self or others; regular observation;
  - d. periodical reassessments of the need for restraint (e.g. every half hour for physical restraint);

- e. a strictly limited duration (e.g. 4 hours for physical restraint);
- f. documentation in patient's medical file.

### **Implementation**

Selected actions suggested to promote this principle are:

1. Maintaining legal instruments and infrastructures (human resources, sites, etc.) to support community-based mental health care involving settings for patients with various degrees of autonomy;
2. Taking steps to eliminate isolation rooms and prohibit the creation of new ones;
3. Amending relevant legal instruments to remove provisions incompatible with community-based mental health care;
4. Training mental health care providers in the use of alternatives to the traditional restraints to deal with crisis situations.

## **5. SELF-DETERMINATION**

### **Description**

Consent is required before any type of interference with a person can occur.

### **Components**

This principle includes the following components:

1. Interference includes:
  - a. bodily and mental integrity (e.g. diagnostic procedures, medical treatment, such as use of drugs, electroconvulsive therapy and irreversible surgery);
  - b. liberty (e.g. mandatory commitment to hospital).
2. Consent must be:
  - a. given by the person involved, as may apply in keeping with cultures, after having obtained advice from any traditional decision-making unit (e.g. family, relative, work unit);
  - b. free (of undue influence);
  - c. informed (information to be accurate, understandable, sufficient for one to decide e.g. advantages, disadvantages, risks, alternatives, expected results, side-effects);
  - d. documented in the patient's medical file, except for minor interferences.
3. In case a person with a mental disorder is found to be unable to consent, which will typically be the case occasionally but not systematically, there should be a surrogate decision-maker (relative, friend or authority) authorized to decide on the patient's behalf and in the patient's best interest. Parents or guardians, if any, are to give consent for minors.

### **Implementation**

Selected actions suggested to promote this principle are:

1. Presuming that patients are capable of making their own decision unless proven otherwise;
2. Making sure that mental health care providers do not systematically consider that patients with a mental disorder are unable to make their own decisions;
3. Not systematically considering a patient to be unable to exercise self-

determination with regard to all components (e.g. integrity, liberty) because the patient was found to be unable with regard to one (e.g. authority for involuntary hospitalization does not automatically include authority for involuntary treatment, especially if the treatment is invasive);

4. Giving verbal and written information (in an accessible language) to patients about the treatment; detailed verbal explanations should be provided to patients unable to read;
5. Calling for the patient's opinion regardless of his or her ability to consent and giving it careful consideration prior to carrying out actions affecting his/her integrity or liberty; asking someone deemed unable to decide about his/her own good to explain the motives behind a given opinion may unveil legitimate concerns for consideration and, as such, promotes the exercise of self-determination;
6. Abiding by any wishes expressed by a patient prior to becoming unable to consent.

## **6. RIGHT TO BE ASSISTED IN THE EXERCISE OF SELF-DETERMINATION**

### **Description**

In case a patient merely experiences difficulties in appreciating the implications of a decision, although not unable to decide, he/she shall benefit from the assistance of a knowledgeable third party of his or her choice.

### **Components**

Difficulties may be due to various causes, including the following:

1. General knowledge;
2. Linguistic abilities;
3. Disability resulting from a health disorder.

### **Implementation**

Selected actions suggested to further respect of this principle include:

1. Informing the patient about this right at the moment he/she is faced with the need for assistance;
2. Suggesting potential assistants (e.g. a lawyer, a social worker);
3. Facilitating the involvement of the assistant, including offering assistance free of charge if possible;
4. Promoting the establishment of a structure offering assistance to mental patients (e.g. ombudsman, patients' (users') committee).

## **7. AVAILABILITY OF REVIEW PROCEDURE**

### **Description**

There should be a review procedure available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers.

### **Components**

This principle includes the following components:

1. The procedure should be available at the request of interested parties, including the person involved;
2. The procedure should be available in a timely fashion (e.g. within 3 days of the decision);
3. The patient should not be prevented to access review on the basis of his/her health status;
4. The patient should be given an opportunity to be heard in person.

#### **Implementation**

Selected actions suggested to promote this principle are:

1. Having a review procedure and/or a permanent Review Board created by legislation and which is operational;
2. Establishing a state-managed office of representatives for mental patients with legal and ombudsman-like services.

### **8. AUTOMATIC PERIODICAL REVIEW MECHANISM**

#### **Description**

In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism.

#### **Components**

This principle includes the following components:

1. Reviews should take place automatically;
2. Reviews should take place at reasonable intervals (e.g. each time a six-month period has elapsed);
3. Reviews should be conducted by a qualified decision-maker acting in official capacity.

#### **Implementation**

Selected actions suggested to promote this principle are:

1. Appointing a review body to conduct this review;
2. Requiring members of the review body to meet patients and review cases at a set interval;
3. Entitling patients to meet the review body (this should be facilitated by the health authorities);
4. Requiring the review procedure to take place in full upon each occasion (the review body should ideally not be composed of the same person(s) if more than one automatic review occurs in a given case and it should not be unduly influenced by its previous decisions);
5. Sanctioning defaulting body members (e.g. those failing to carry out the tasks for which they are appointed).

### **9. QUALIFIED DECISION-MAKER**

#### **Description**

Decision-makers acting in official capacity (e.g. judge) or surrogate (consent-giving) capacity (e.g. relative, friend, guardian) shall be qualified to do so.

**Components**

To be qualified, decision-makers should be:

1. Competent;
2. Knowledgeable;
3. Independent (if acting in official capacity);
4. Impartial (if acting in official capacity).

Ideally, a decision-making body acting in an official capacity should be composed of more than one person (e.g. three) drawn from different relevant disciplines.

**Implementation**

Selected actions suggested to promote this principle are:

1. Providing initial and continuing training to decision-makers acting in official capacity and/or their assistants in relevant disciplines, including, as needed, psychiatry, psychology, law, social services and other disciplines;
2. Disqualifying decision-makers with a direct personal interest in the determination at stake;
3. Providing sufficient remuneration to decision-makers acting in official capacity to guarantee independence in carrying out their duty.

**10. RESPECT OF THE RULE OF LAW****Description**

Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis.

**Components**

This principle includes the following components:

1. Depending on the legal system of the country, the body of law may be found in different types of legal instruments (e.g. constitutions, international agreements, laws, decrees, regulations, orders) and/or in past court rulings (precedents);
2. The law applicable is the law in force at the time in question, as opposed to retroactive or draft legal instruments;
3. Laws should be public, accessible and made understandable.

**Implementation**

Selected actions suggested to promote this principle are:

1. Informing patients about their rights;
2. Making sure that relevant legal instruments are disseminated (e.g. published, explained in accessible language in guides, if necessary) to interested members of the public in general and to decision-makers in particular;
3. Providing training to decision-makers on the meaning and implications of the rule of law;
4. Drawing from relevant internationally accepted human rights' documents, (e.g. UN Principles, current Ten Basic Principles) to interpret the body of law in force in the jurisdiction involved;
5. Having the actual application of the mental health law scheme monitored by a control body independent from the health authorities and from the health care providers.

This is an edited version of a document of the same title (WHO/MNH/MND/96.9), which is itself an edited version of a WHO document which lists and describes ten basic principles of mental health care law. It also provides annotations for their implementation in practice.

Available online at: [http://www.who.int/mental\\_health/media/en/75.pdf](http://www.who.int/mental_health/media/en/75.pdf)

# 17/PRISONERS AND PRISON SETTINGS

- Standard Minimum Rules for the Treatment of Prisoners (United Nations, 1955, last revised 1984)
- The Oath of Athens (International Council of Prison Medical Services, 1977)
- Principles of Medical Ethics (United Nations, 1982)
- Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment (United Nations, 1988)
- Basic Principles for the Treatment of Prisoners (United Nations General Assembly, 1990)
- Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990)
- Statement on Body Searches of Prisoners (World Medical Association, 1993, last revised 2005)
- Position Statement on the Nurse's Role in the Care of Detainees and Prisoners (International Council of Nurses, 1998, last revised 2006)

## STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS

*(United Nations, 1955, 1977, 1984)*

### PRELIMINARY OBSERVATIONS

**1.** The following rules are not intended to describe in detail a model system of penal institutions. They seek only, on the basis of the general consensus of contemporary thought and the essential elements of the most adequate systems of today, to set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions.

**2.** In view of the great variety of legal, social, economic and geographical conditions of the world, it is evident that not all of the rules are capable of application in all places and at all times. They should, however, serve to stimulate a constant endeavour to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations.

**3.** On the other hand, the rules cover a field in which thought is constantly developing. They are not intended to preclude experiment and practices, provided these are in harmony with the principles and seek to further the purposes which derive from the text of the rules as a whole. It will always be justifiable for the central prison administration to authorize departures from the rules in this spirit.

**4. 1.** Part I of the rules covers the general management of institutions, and is applicable to all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to “security measures” or corrective measures ordered by the judge.

**2.** Part II contains rules applicable only to the special categories dealt with in each section. Nevertheless, the rules under section A, applicable to prisoners under sentence, shall be equally applicable to categories of prisoners dealt with in sections B, C and D, provided they do not conflict with the rules governing those categories and are for their benefit.

**5. 1.** The rules do not seek to regulate the management of institutions set aside for young persons such as Borstal institutions or correctional schools, but in general part I would be equally applicable in such institutions.

**2.** The category of young prisoners should include at least all young persons who come within the jurisdiction of juvenile courts. As a rule, such young persons should not be sentenced to imprisonment.

## **PART I – RULES OF GENERAL APPLICATION**

### **Basic principle**

**6. 1.** The following rules shall be applied impartially. There shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

**2.** On the other hand, it is necessary to respect the religious beliefs and moral precepts of the group to which a prisoner belongs.

### **Register**

**7. 1.** In every place where persons are imprisoned there shall be kept a bound registration book with numbered pages in which shall be entered in respect of each prisoner received:

- a.** Information concerning his identity;
- b.** The reasons for his commitment and the authority therefor;
- c.** The day and hour of his admission and release.

**2.** No person shall be received in an institution without a valid commitment order of which the details shall have been previously entered in the register.

### **Separation of categories**

**8.** The different categories of prisoners shall be kept in separate institutions or parts of institutions taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment. Thus,

- a.** Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women the whole of the premises allocated to women shall be entirely separate;
- b.** Untried prisoners shall be kept separate from convicted prisoners;
- c.** Persons imprisoned for debt and other civil prisoners shall be kept

- separate from persons imprisoned by reason of a criminal offence;
- d. Young prisoners shall be kept separate from adults.

### **Accommodation**

**9. 1.** Where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself. If for special reasons, such as temporary overcrowding, it becomes necessary for the central prison administration to make an exception to this rule, it is not desirable to have two prisoners in a cell or room.

**2.** Where dormitories are used, they shall be occupied by prisoners carefully selected as being suitable to associate with one another in those conditions. There shall be regular supervision by night, in keeping with the nature of the institution.

**10.** All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.

**11.** In all places where prisoners are required to live or work,

- a. The windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation;
- b. Artificial light shall be provided sufficient for the prisoners to read or work without injury to eyesight.

**12.** The sanitary installations shall be adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner.

**13.** Adequate bathing and shower installations shall be provided so that every prisoner may be enabled and required to have a bath or shower, at a temperature suitable to the climate, as frequently as necessary for general hygiene according to season and geographical region, but at least once a week in a temperate climate.

**14.** All pans of an institution regularly used by prisoners shall be properly maintained and kept scrupulously clean at all times.

### **Personal hygiene**

**15.** Prisoners shall be required to keep their persons clean, and to this end they shall be provided with water and with such toilet articles as are necessary for health and cleanliness.

**16.** In order that prisoners may maintain a good appearance compatible with their self-respect, facilities shall be provided for the proper care of the hair and beard, and men shall be enabled to shave regularly.

### **Clothing and bedding**

**17. 1.** Every prisoner who is not allowed to wear his own clothing shall be provided with an outfit of clothing suitable for the climate and adequate to keep him in good health. Such clothing shall in no manner be degrading or humiliating.

2. All clothing shall be clean and kept in proper condition. Underclothing shall be changed and washed as often as necessary for the maintenance of hygiene.

3. In exceptional circumstances, whenever a prisoner is removed outside the institution for an authorized purpose, he shall be allowed to wear his own clothing or other inconspicuous clothing.

18. If prisoners are allowed to wear their own clothing, arrangements shall be made on their admission to the institution to ensure that it shall be clean and fit for use.

19. Every prisoner shall, in accordance with local or national standards, be provided with a separate bed, and with separate and sufficient bedding which shall be clean when issued, kept in good order and changed often enough to ensure its cleanliness.

### **Food**

20. 1. Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.

2. Drinking water shall be available to every prisoner whenever he needs it.

### **Exercise and sport**

21. 1. Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits.

2. Young prisoners, and others of suitable age and physique, shall receive physical and recreational training during the period of exercise. To this end space, installations and equipment should be provided.

### **Medical services**

22. 1. At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

2. Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

3. The services of a qualified dental officer shall be available to every prisoner.

23. 1. In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

2. Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

**24.** The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

**25. 1.** The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

**2.** The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

**26. 1.** The medical officer shall regularly inspect and advise the director upon:

- a.** The quantity, quality, preparation and service of food;
- b.** The hygiene and cleanliness of the institution and the prisoners;
- c.** The sanitation, heating, lighting and ventilation of the institution;
- d.** The suitability and cleanliness of the prisoners' clothing and bedding;
- e.** The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

**2.** The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

### **Discipline and punishment**

**27.** Discipline and order shall be maintained with firmness, but with no more restriction than is necessary for safe custody and well-ordered community life.

**28. 1.** No prisoner shall be employed, in the service of the institution, in any disciplinary capacity.

**2.** This rule shall not, however, impede the proper functioning of systems based on self-government, under which specified social, educational or sports activities or responsibilities are entrusted, under supervision, to prisoners who are formed into groups for the purposes of treatment.

**29.** The following shall always be determined by the law or by the regulation of the competent administrative authority:

- a.** Conduct constituting a disciplinary offence;
- b.** The types and duration of punishment which may be inflicted;
- c.** The authority competent to impose such punishment.

**30. 1.** No prisoner shall be punished except in accordance with the terms of such law or regulation, and never twice for the same offence.

**2.** No prisoner shall be punished unless he has been informed of the offence

alleged against him and given a proper opportunity of presenting his defence. The competent authority shall conduct a thorough examination of the case.

**3.** Where necessary and practicable the prisoner shall be allowed to make his defence through an interpreter.

**31.** Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

**32. 1.** Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

**2.** The same shall apply to any other punishment that may be prejudicial to the physical or mental health of a prisoner. In no case may such punishment be contrary to or depart from the principle stated in rule 31.

**3.** The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

#### **Instruments of restraint**

**33.** Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:

- a.** As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;
- b.** On medical grounds by direction of the medical officer;
- c.** By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.

**34.** The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary.

#### **Information to and complaints by prisoners**

**35. 1.** Every prisoner on admission shall be provided with written information about the regulations governing the treatment of prisoners of his category, the disciplinary requirements of the institution, the authorized methods of seeking information and making complaints, and all such other matters as are necessary to enable him to understand both his rights and his obligations and to adapt himself to the life of the institution.

**2.** If a prisoner is illiterate, the aforesaid information shall be conveyed to him orally.

**36. 1.** Every prisoner shall have the opportunity each week day of making requests or complaints to the director of the institution or the officer authorized to represent him.

**2.** It shall be possible to make requests or complaints to the inspector of prisons during his inspection. The prisoner shall have the opportunity to talk to the inspector or to any other inspecting officer without the director or other members of the staff being present.

**3.** Every prisoner shall be allowed to make a request or complaint, without censorship as to substance but in proper form, to the central prison administration, the judicial authority or other proper authorities through approved channels.

**4.** Unless it is evidently frivolous or groundless, every request or complaint shall be promptly dealt with and replied to without undue delay.

#### **Contact with the outside world**

**37.** Prisoners shall be allowed under necessary supervision to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits.

**38. 1.** Prisoners who are foreign nationals shall be allowed reasonable facilities to communicate with the diplomatic and consular representatives of the State to which they belong.

**2.** Prisoners who are nationals of States without diplomatic or consular representation in the country and refugees or stateless persons shall be allowed similar facilities to communicate with the diplomatic representative of the State which takes charge of their interests or any national or international authority whose task it is to protect such persons.

**39.** Prisoners shall be kept informed regularly of the more important items of news by the reading of newspapers, periodicals or special institutional publications, by hearing wireless transmissions, by lectures or by any similar means as authorized or controlled by the administration.

#### **Books**

**40.** Every institution shall have a library for the use of all categories of prisoners, adequately stocked with both recreational and instructional books, and prisoners shall be encouraged to make full use of it.

#### **Religion**

**41. 1.** If the institution contains a sufficient number of prisoners of the same religion, a qualified representative of that religion shall be appointed or approved. If the number of prisoners justifies it and conditions permit, the arrangement should be on a full-time basis.

**2.** A qualified representative appointed or approved under paragraph (1) shall be allowed to hold regular services and to pay pastoral visits in private to prisoners of his religion at proper times.

3. Access to a qualified representative of any religion shall not be refused to any prisoner. On the other hand, if any prisoner should object to a visit of any religious representative, his attitude shall be fully respected.

42. So far as practicable, every prisoner shall be allowed to satisfy the needs of his religious life by attending the services provided in the institution and having in his possession the books of religious observance and instruction of his denomination.

#### **Retention of prisoners' property**

43. 1. All money, valuables, clothing and other effects belonging to a prisoner which under the regulations of the institution he is not allowed to retain shall on his admission to the institution be placed in safe custody. An inventory thereof shall be signed by the prisoner. Steps shall be taken to keep them in good condition.

2. On the release of the prisoner all such articles and money shall be returned to him except in so far as he has been authorized to spend money or send any such property out of the institution, or it has been found necessary on hygienic grounds to destroy any article of clothing. The prisoner shall sign a receipt for the articles and money returned to him.

3. Any money or effects received for a prisoner from outside shall be treated in the same way.

4. If a prisoner brings in any drugs or medicine, the medical officer shall decide what use shall be made of them.

#### **Notification of death, illness, transfer, etc.**

44. 1. Upon the death or serious illness of, or serious injury to a prisoner, or his removal to an institution for the treatment of mental affections, the director shall at once inform the spouse, if the prisoner is married, or the nearest relative and shall in any event inform any other person previously designated by the prisoner.

2. A prisoner shall be informed at once of the death or serious illness of any near relative. In case of the critical illness of a near relative, the prisoner should be authorized, whenever circumstances allow, to go to his bedside either under escort or alone.

3. Every prisoner shall have the right to inform at once his family of his imprisonment or his transfer to another institution.

#### **Removal of prisoners**

45. 1. When the prisoners are being removed to or from an institution, they shall be exposed to public view as little as possible, and proper safeguards shall be adopted to protect them from insult, curiosity and publicity in any form.

2. The transport of prisoners in conveyances with inadequate ventilation or light, or in any way which would subject them to unnecessary physical hardship, shall be prohibited.

3. The transport of prisoners shall be carried out at the expense of the administration and equal conditions shall obtain for all of them.

### **Institutional personnel**

**46. 1.** The prison administration, shall provide for the careful selection of every grade of the personnel, since it is on their integrity, humanity, professional capacity and personal suitability for the work that the proper administration of the institutions depends.

**2.** The prison administration shall constantly seek to awaken and maintain in the minds both of the personnel and of the public the conviction that this work is a social service of great importance, and to this end all appropriate means of informing the public should be used.

**3.** To secure the foregoing ends, personnel shall be appointed on a full-time basis as professional prison officers and have civil service status with security of tenure subject only to good conduct, efficiency and physical fitness. Salaries shall be adequate to attract and retain suitable men and women; employment benefits and conditions of service shall be favourable in view of the exacting nature of the work.

**47. 1.** The personnel shall possess an adequate standard of education and intelligence.

**2.** Before entering on duty, the personnel shall be given a course of training in their general and specific duties and be required to pass theoretical and practical tests.

**3.** After entering on duty and during their career, the personnel shall maintain and improve their knowledge and professional capacity by attending courses of in-service training to be organized at suitable intervals.

**48.** All members of the personnel shall at all times so conduct themselves and perform their duties as to influence the prisoners for good by their example and to command their respect.

**49. 1.** So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors.

**2.** The services of social workers, teachers and trade instructors shall be secured on a permanent basis, without thereby excluding part-time or voluntary workers.

**50. 1.** The director of an institution should be adequately qualified for his task by character, administrative ability, suitable training and experience.

**2.** He shall devote his entire time to his official duties and shall not be appointed on a part-time basis.

**3.** He shall reside on the premises of the institution or in its immediate vicinity.

**4.** When two or more institutions are under the authority of one director, he shall visit each of them at frequent intervals. A responsible resident official shall be in charge of each of these institutions.

**51. 1.** The director, his deputy, and the majority of the other personnel of the institution shall be able to speak the language of the greatest number of prisoners, or a language understood by the greatest number of them.

**2.** Whenever necessary, the services of an interpreter shall be used.

**52. 1.** In institutions which are large enough to require the services of one or more full-time medical officers, at least one of them shall reside on the premises of the institution or in its immediate vicinity.

2. In other institutions the medical officer shall visit daily and shall reside near enough to be able to attend without delay in cases of urgency.

53. 1. In an institution for both men and women, the part of the institution set aside for women shall be under the authority of a responsible woman officer who shall have the custody of the keys of all that part of the institution.

2. No male member of the staff shall enter the part of the institution set aside for women unless accompanied by a woman officer.

3. Women prisoners shall be attended and supervised only by women officers. This does not, however, preclude male members of the staff, particularly doctors and teachers, from carrying out their professional duties in institutions or parts of institutions set aside for women.

54. 1. Officers of the institutions shall not, in their relations with the prisoners, use force except in self-defence or in cases of attempted escape, or active or passive physical resistance to an order based on law or regulations. Officers who have recourse to force must use no more than is strictly necessary and must report the incident immediately to the director of the institution.

2. Prison officers shall be given special physical training to enable them to restrain aggressive prisoners.

3. Except in special circumstances, staff performing duties which bring them into direct contact with prisoners should not be armed. Furthermore, staff should in no circumstances be provided with arms unless they have been trained in their use.

### **Inspection**

55. There shall be a regular inspection of penal institutions and services by qualified and experienced inspectors appointed by a competent authority. Their task shall be in particular to ensure that these institutions are administered in accordance with existing laws and regulations and with a view to bringing about the objectives of penal and correctional services.

## **PART II – RULES APPLICABLE TO SPECIAL CATEGORIES**

### **A. Prisoners under Sentence**

#### *Guiding principles*

56. The guiding principles hereafter are intended to show the spirit in which penal institutions should be administered and the purposes at which they should aim, in accordance with the declaration made under Preliminary Observation I of the present text.

57. Imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation.

58. The purpose and justification of a sentence of imprisonment or a similar measure deprivative of liberty is ultimately to protect society against crime. This end

can only be achieved if the period of imprisonment is used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life.

**59.** To this end, the institution should utilize all the remedial, educational, moral, spiritual and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners.

**60. 1.** The regime of the institution should seek to minimize any differences between prison life and life at liberty which tend to lessen the responsibility of the prisoners or the respect due to their dignity as human beings.

**2.** Before the completion of the sentence, it is desirable that the necessary steps be taken to ensure for the prisoner a gradual return to life in society. This aim may be achieved, depending on the case, by a pre-release regime organized in the same institution or in another appropriate institution, or by release on trial under some kind of supervision which must not be entrusted to the police but should be combined with effective social aid.

**61.** The treatment of prisoners should emphasize not their exclusion from the community, but their continuing part in it. Community agencies should, therefore, be enlisted wherever possible to assist the staff of the institution in the task of social rehabilitation of the prisoners. There should be in connection with every institution social workers charged with the duty of maintaining and improving all desirable relations of a prisoner with his family and with valuable social agencies. Steps should be taken to safeguard, to the maximum extent compatible with the law and the sentence, the rights relating to civil interests, social security rights and other social benefits of prisoners.

**62.** The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

**63. 1.** The fulfilment of these principles requires individualization of treatment and for this purpose a flexible system of classifying prisoners in groups; it is therefore desirable that such groups should be distributed in separate institutions suitable for the treatment of each group.

**2.** These institutions need not provide the same degree of security for every group. It is desirable to provide varying degrees of security according to the needs of different groups. Open institutions, by the very fact that they provide no physical security against escape but rely on the self-discipline of the inmates, provide the conditions most favourable to rehabilitation for carefully selected prisoners.

**3.** It is desirable that the number of prisoners in closed institutions should not be so large that the individualization of treatment is hindered. In some countries it is considered that the population of such institutions should not exceed five hundred. In open institutions the population should be as small as possible.

**4.** On the other hand, it is undesirable to maintain prisons which are so small that proper facilities cannot be provided.

64. The duty of society does not end with a prisoner's release. There should, therefore, be governmental or private agencies capable of lending the released prisoner efficient after-care directed towards the lessening of prejudice against him and towards his social rehabilitation.

### **Treatment**

65. The treatment of persons sentenced to imprisonment or a similar measure shall have as its purpose, so far as the length of the sentence permits, to establish in them the will to lead law-abiding and self-supporting lives after their release and to fit them to do so. The treatment shall be such as will encourage their self-respect and develop their sense of responsibility.

66. 1. To these ends, all appropriate means shall be used, including religious care in the countries where this is possible, education, vocational guidance and training, social casework, employment counselling, physical development and strengthening of moral character, in accordance with the individual needs of each prisoner, taking account of his social and criminal history, his physical and mental capacities and aptitudes, his personal temperament, the length of his sentence and his prospects after release.

2. For every prisoner with a sentence of suitable length, the director shall receive, as soon as possible after his admission, full reports on all the matters referred to in the foregoing paragraph. Such reports shall always include a report by a medical officer, wherever possible qualified in psychiatry, on the physical and mental condition of the prisoner.

3. The reports and other relevant documents shall be placed in an individual file. This file shall be kept up to date and classified in such a way that it can be consulted by the responsible personnel whenever the need arises.

### **Classification and individualization**

67. The purposes of classification shall be:

- a. To separate from others those prisoners who, by reason of their criminal records or bad characters, are likely to exercise a bad influence;
- b. To divide the prisoners into classes in order to facilitate their treatment with a view to their social rehabilitation.

68. So far as possible separate institutions or separate sections of an institution shall be used for the treatment of the different classes of prisoners.

69. As soon as possible after admission and after a study of the personality of each prisoner with a sentence of suitable length, a programme of treatment shall be prepared for him in the light of the knowledge obtained about his individual needs, his capacities and dispositions.

### **Privileges**

70. Systems of privileges appropriate for the different classes of prisoners and the different methods of treatment shall be established at every institution, in order to

encourage good conduct, develop a sense of responsibility and secure the interest and co-operation of the prisoners in their treatment.

### **Work**

- 71.** 1. Prison labour must not be of an afflictive nature.  
 2. All prisoners under sentence shall be required to work, subject to their physical and mental fitness as determined by the medical officer.  
 3. Sufficient work of a useful nature shall be provided to keep prisoners actively employed for a normal working day.  
 4. So far as possible the work provided shall be such as will maintain or increase the prisoners, ability to earn an honest living after release.  
 5. Vocational training in useful trades shall be provided for prisoners able to profit thereby and especially for young prisoners.  
 6. Within the limits compatible with proper vocational selection and with the requirements of institutional administration and discipline, the prisoners shall be able to choose the type of work they wish to perform.
- 72.** 1. The organization and methods of work in the institutions shall resemble as closely as possible those of similar work outside institutions, so as to prepare prisoners for the conditions of normal occupational life.  
 2. The interests of the prisoners and of their vocational training, however, must not be subordinated to the purpose of making a financial profit from an industry in the institution.
- 73.** 1. Preferably institutional industries and farms should be operated directly by the administration and not by private contractors.  
 2. Where prisoners are employed in work not controlled by the administration, they shall always be under the supervision of the institution's personnel. Unless the work is for other departments of the government the full normal wages for such work shall be paid to the administration by the persons to whom the labour is supplied, account being taken of the output of the prisoners.
- 74.** 1. The precautions laid down to protect the safety and health of free workmen shall be equally observed in institutions.  
 2. Provision shall be made to indemnify prisoners against industrial injury, including occupational disease, on terms not less favourable than those extended by law to free workmen.
- 75.** 1. The maximum daily and weekly working hours of the prisoners shall be fixed by law or by administrative regulation, taking into account local rules or custom in regard to the employment of free workmen.  
 2. The hours so fixed shall leave one rest day a week and sufficient time for education and other activities required as part of the treatment and rehabilitation of the prisoners.
- 76.** 1. There shall be a system of equitable remuneration of the work of prisoners.  
 2. Under the system prisoners shall be allowed to spend at least a part of

their earnings on approved articles for their own use and to send a part of their earnings to their family.

**3.** The system should also provide that a part of the earnings should be set aside by the administration so as to constitute a savings fund to be handed over to the prisoner on his release. Education and recreation

**77. 1.** Provision shall be made for the further education of all prisoners capable of profiting thereby, including religious instruction in the countries where this is possible. The education of illiterates and young prisoners shall be compulsory and special attention shall be paid to it by the administration.

**2.** So far as practicable, the education of prisoners shall be integrated with the educational system of the country so that after their release they may continue their education without difficulty.

**78.** Recreational and cultural activities shall be provided in all institutions for the benefit of the mental and physical health of prisoners.

#### **Social relations and after-care**

**79.** Special attention shall be paid to the maintenance and improvement of such relations between a prisoner and his family as are desirable in the best interests of both.

**80.** From the beginning of a prisoner's sentence consideration shall be given to his future after release and he shall be encouraged and assisted to maintain or establish such relations with persons or agencies outside the institution as may promote the best interests of his family and his own social rehabilitation.

**81. 1.** Services and agencies, governmental or otherwise, which assist released prisoners to re-establish themselves in society shall ensure, so far as is possible and necessary, that released prisoners be provided with appropriate documents and identification papers, have suitable homes and work to go to, are suitably and adequately clothed having regard to the climate and season, and have sufficient means to reach their destination and maintain themselves in the period immediately following their release.

**2.** The approved representatives of such agencies shall have all necessary access to the institution and to prisoners and shall be taken into consultation as to the future of a prisoner from the beginning of his sentence.

**3.** It is desirable that the activities of such agencies shall be centralized or co-ordinated as far as possible in order to secure the best use of their efforts.

#### **B. INSANE AND MENTALLY ABNORMAL PRISONERS**

**82. 1.** Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.

**2.** Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.

**3.** During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.

**4.** The medical or psychiatric service of the penal institutions shall provide

for the psychiatric treatment of all other prisoners who are in need of such treatment.

**83.** It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care.

### **C. PRISONERS UNDER ARREST OR AWAITING TRIAL**

**84. 1.** Persons arrested or imprisoned by reason of a criminal charge against them, who are detained either in police custody or in prison custody (jail) but have not yet been tried and sentenced, will be referred to as “untried prisoners,” hereinafter in these rules.

**2.** Unconvicted prisoners are presumed to be innocent and shall be treated as such.

**3.** Without prejudice to legal rules for the protection of individual liberty or prescribing the procedure to be observed in respect of untried prisoners, these prisoners shall benefit by a special regime which is described in the following rules in its essential requirements only.

**85. 1.** Untried prisoners shall be kept separate from convicted prisoners.

**2.** Young untried prisoners shall be kept separate from adults and shall in principle be detained in separate institutions.

**86.** Untried prisoners shall sleep singly in separate rooms, with the reservation of different local custom in respect of the climate.

**87.** Within the limits compatible with the good order of the institution, untried prisoners may, if they so desire, have their food procured at their own expense from the outside, either through the administration or through their family or friends. Otherwise, the administration shall provide their food.

**88. 1.** An untried prisoner shall be allowed to wear his own clothing if it is clean and suitable.

**2.** If he wears prison dress, it shall be different from that supplied to convicted prisoners.

**89.** An untried prisoner shall always be offered opportunity to work, but shall not be required to work. If he chooses to work, he shall be paid for it.

**90.** An untried prisoner shall be allowed to procure at his own expense or at the expense of a third party such books, newspapers, writing materials and other means of occupation as are compatible with the interests of the administration of justice and the security and good order of the institution.

**91.** An untried prisoner shall be allowed to be visited and treated by his own doctor or dentist if there is reasonable ground for his application and he is able to pay any expenses incurred.

**92.** An untried prisoner shall be allowed to inform immediately his family of his detention and shall be given all reasonable facilities for communicating with his family and friends, and for receiving visits from them, subject only to restrictions and supervision as are necessary in the interests of the administration of justice and of the security and good order of the institution.

**93.** For the purposes of his defence, an untried prisoner shall be allowed to apply for free legal aid where such aid is available, and to receive visits from his legal adviser with a view to his defence and to prepare and hand to him confidential instructions. For these purposes, he shall if he so desires be supplied with writing material. Interviews between the prisoner and his legal adviser may be within sight but not within the hearing of a police or institution official.

#### **D. Civil Prisoners**

**94.** In countries where the law permit its imprisonment for debt, or by order of a court under any other non-criminal process, persons so imprisoned shall not be subjected to any greater restriction or severity than is necessary to ensure safe custody and good order. Their treatment shall be not less favourable than that of untried prisoners, with the reservation, however, that they may possibly be required to work.

#### **E. Persons Arrested or Detained Without Charge**

**95.** Without prejudice to the provisions of article 9 of the International Covenant on Civil and Political Rights, persons arrested or imprisoned without charge shall be accorded the same protection as that accorded under part I and part II, section C. Relevant provisions of part II, section A, shall likewise be applicable where their application may be conducive to the benefit of this special group of persons in custody, provided that no measures shall be taken implying that re-education or rehabilitation is in any way appropriate to persons not convicted of any criminal offence.

Source: Standard Minimum Rules for the Treatment of Prisoners, adopted Aug. 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, E.S.C. res. 663C, 24 U.N. ESCOR Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (No. 1) at 35, U.N. Doc. E/5988 (1977).

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp34.htm](http://www.unhchr.ch/html/menu3/b/h_comp34.htm)

## **THE OATH OF ATHENS**

*(International Council of Prison Medical Services, 1977)*

We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1977, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics.

We recognize the right of the incarcerated individuals to receive the best possible health care.

We undertake

- 1.** To abstain from authorizing or approving any physical punishment.

2. To abstain from participating in any form of torture.
3. Not to engage in any form of human experimentation amongst incarcerated individuals without their informed consent.
4. To respect the confidentiality of any information obtained in the course of our professional relationships with incarcerated patients.
5. That our medical judgements be based on the needs of our patients and take priority over any non-medical matters.

Available online at:

[http://www.prisonhealthcarepractitioners.com/Medical\\_ethics.shtml](http://www.prisonhealthcarepractitioners.com/Medical_ethics.shtml)

## PRINCIPLES OF MEDICAL ETHICS

*(United Nations, 1982)*

Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment.

### Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have the duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

### Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.<sup>1</sup>

---

1. See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly Resolution 3452 (XXX), annex), article 1 of which states:

“1. For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.”

Article 7 of the Declaration states:

“Each state shall ensure that all acts of torture as defined in article 1 are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture.”

**Principle 3**

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not to solely evaluate, protect or improve their physical and mental health.

**Principle 4**

It is a contravention of medical ethics for health personnel, particularly physicians:

- a. To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;
- b. To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.<sup>2</sup>

**Principle 5**

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

**Principle 6**

There may be no derogation from the foregoing principles on any grounds whatsoever, including public emergency.

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp40.htm](http://www.unhchr.ch/html/menu3/b/h_comp40.htm)

---

2. Particularly the Universal Declaration of Human Rights (General Assembly Resolution 217 A (III)), the International Covenants on Human Rights (General Assembly Resolution 2200 A (XXI), annex), the Declaration on the Protection of all Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly Resolution 3452 (XXX), annex) and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. 1956.IV.4), annex IA).

## BODY OF PRINCIPLES FOR THE PROTECTION OF ALL PERSONS UNDER ANY FORM OF DETENTION OR IMPRISONMENT

*(United Nations, 1988)*

### *Scope of the Body of Principles*

These principles apply for the protection of all persons under any form of detention or imprisonment.

### *Use of Terms*

For the purposes of the Body of Principles:

- a. “Arrest” means the act of apprehending a person for the alleged commission of an offence or by the action of an authority;
- b. “Detained” person means any person deprived of personal liberty except as a result of conviction for an offence;
- c. “Imprisoned person” means any person deprived of personal liberty as a result of conviction for an offence;
- d. “Detention” means the condition of detained persons as defined above;
- e. “Imprisonment” means the condition of imprisoned persons as defined above;
- f. The words “a judicial or other authority” mean a judicial or other authority under the law whose status and tenure should afford the strongest possible guarantees of competence, impartiality and independence.

### **Principle 1**

All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person.

### **Principle 2**

Arrest, detention or imprisonment shall only be carried out strictly in accordance with the provisions of the law and by competent officials or persons authorized for that purpose.

### **Principle 3**

There shall be no restriction upon or derogation from any of the human rights of persons under any form of detention or imprisonment recognized or existing in any State pursuant to law, conventions, regulations or custom on the pretext that this Body of Principles does not recognize such rights or that it recognizes them to a lesser extent.

### **Principle 4**

Any form of detention or imprisonment and all measures affecting the human rights of a person under any form of detention or imprisonment shall be ordered by, or be subject to the effective control of, a judicial or other authority.

**Principle 5**

1. These principles shall be applied to all persons within the territory of any given State, without distinction of any kind, such as race, colour, sex, language, religion or religious belief, political or other opinion, national, ethnic or social origin, property, birth or other status.

2. Measures applied under the law and designed solely to protect the rights and special status of women, especially pregnant women and nursing mothers, children and juveniles, aged, sick or handicapped persons shall not be deemed to be discriminatory. The need for, and the application of, such measures shall always be subject to review by a judicial or other authority.

**Principle 6**

No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.<sup>1</sup> No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment.

**Principle 7**

1. States should prohibit by law any act contrary to the rights and duties contained in these principles, make any such act subject to appropriate sanctions and conduct impartial investigations upon complaints.

2. Officials who have reason to believe that a violation of this Body of Principles has occurred or is about to occur shall report the matter to their superior authorities and, where necessary, to other appropriate authorities or organs vested with reviewing or remedial powers.

3. Any other person who has ground to believe that a violation of this Body of Principles has occurred or is about to occur shall have the right to report the matter to the superiors of the officials involved as well as to other appropriate authorities or organs vested with reviewing or remedial powers.

**Principle 8**

Persons in detention shall be subject to treatment appropriate to their unconvicted status. Accordingly, they shall, whenever possible, be kept separate from imprisoned persons.

**Principle 9**

The authorities which arrest a person, keep him under detention or investigate the case shall exercise only the powers granted to them under the law and the exercise of these powers shall be subject to recourse to a judicial or other authority.

---

1. The term "cruel, inhuman or degrading treatment or punishment" should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time.

**Principle 10**

Anyone who is arrested shall be informed at the time of his arrest of the reason for his arrest and shall be promptly informed of any charges against him.

**Principle 11**

1. A person shall not be kept in detention without being given an effective opportunity to be heard promptly by a judicial or other authority. A detained person shall have the right to defend himself or to be assisted by counsel as prescribed by law.
2. A detained person and his counsel, if any, shall receive prompt and full communication of any order of detention, together with the reasons therefore.
3. A judicial or other authority shall be empowered to review as appropriate the continuance of detention.

**Principle 12**

1. There shall be duly recorded:
  - a. The reasons for the arrest;
  - b. The time of the arrest and the taking of the arrested person to a place of custody as well as that of his first appearance before a judicial or other authority;
  - c. The identity of the law enforcement officials concerned;
  - d. Precise information concerning the place of custody.
2. Such records shall be communicated to the detained person, or his counsel, if any, in the form prescribed by law.

**Principle 13**

Any person shall, at the moment of arrest and at the commencement of detention or imprisonment, or promptly thereafter, be provided by the authority responsible for his arrest, detention or imprisonment, respectively, with information on and an explanation of his rights and how to avail himself of such rights.

**Principle 14**

A person who does not adequately understand or speak the language used by the authorities responsible for his arrest, detention or imprisonment is entitled to receive promptly in a language which he understands the information referred to in principle 10, principle 11, paragraph 2, principle 12, paragraph 1, and principle 13 and to have the assistance, free of charge, if necessary, of an interpreter in connection with legal proceedings subsequent to his arrest.

**Principle 15**

Notwithstanding the exceptions contained in principle 16, paragraph 4, and principle 18, paragraph 3, communication of the detained or imprisoned person with the outside world, and in particular his family or counsel, shall not be denied for more than a matter of days.

**Principle 16**

1. Promptly after arrest and after each transfer from one place of detention or imprisonment to another, a detained or imprisoned person shall be entitled to notify or to require the competent authority to notify members of his family or other appropriate persons of his choice of his arrest, detention or imprisonment or of the transfer and of the place where he is kept in custody.
2. If a detained or imprisoned person is a foreigner, he shall also be promptly informed of his right to communicate by appropriate means with a consular post or the diplomatic mission of the State of which he is a national or which is otherwise entitled to receive such communication in accordance with international law or with the representative of the competent international organization, if he is a refugee or is otherwise under the protection of an intergovernmental organization.
3. If a detained or imprisoned person is a juvenile or is incapable of understanding his entitlement, the competent authority shall on its own initiative undertake the notification referred to in the present principle. Special attention shall be given to notifying parents or guardians.
4. Any notification referred to in the present principle shall be made or permitted to be made without delay. The competent authority may however delay a notification for a reasonable period where exceptional needs of the investigation so require.

**Principle 17**

1. A detained person shall be entitled to have the assistance of a legal counsel. He shall be informed of his right by the competent authority promptly after arrest and shall be provided with reasonable facilities for exercising it.
2. If a detained person does not have a legal counsel of his own choice, he shall be entitled to have a legal counsel assigned to him by a judicial or other authority in all cases where the interests of justice so require and without payment by him if he does not have sufficient means to pay.

**Principle 18**

1. A detained or imprisoned person shall be entitled to communicate and consult with his legal counsel.
2. A detained or imprisoned person shall be allowed adequate time and facilities for consultations with his legal counsel.
3. The right of a detained or imprisoned person to be visited by and to consult and communicate, without delay or censorship and in full confidentiality, with his legal counsel may not be suspended or restricted save in exceptional circumstances, to be specified by law or lawful regulations, when it is considered indispensable by a judicial or other authority in order to maintain security and good order.
4. Interviews between a detained or imprisoned person and his legal counsel may be within sight, but not within the hearing, of a law enforcement official.
5. Communications between a detained or imprisoned person and his legal counsel mentioned in the present principle shall be inadmissible as evidence

against the detained or imprisoned person unless they are connected with a continuing or contemplated crime.

**Principle 19**

A detained or imprisoned person shall have the right to be visited by and to correspond with, in particular, members of his family and shall be given adequate opportunity to communicate with the outside world, subject to reasonable conditions and restrictions as specified by law or lawful regulations.

**Principle 20**

If a detained or imprisoned person so requests, he shall if possible be kept in a place of detention or imprisonment reasonably near his usual place of residence.

**Principle 21**

1. It shall be prohibited to take undue advantage of the situation of a detained or imprisoned person for the purpose of compelling him to confess, to incriminate himself otherwise or to testify against any other person.
2. No detained person while being interrogated shall be subject to violence, threats or methods of interrogation which impair his capacity of decision or his judgement.

**Principle 22**

No detained or imprisoned person shall, even with his consent, be subjected to any medical or scientific experimentation which may be detrimental to his health.

**Principle 23**

1. The duration of any interrogation of a detained or imprisoned person and of the intervals between interrogations as well as the identity of the officials who conducted the interrogations and other persons present shall be recorded and certified in such form as may be prescribed by law.
2. A detained or imprisoned person, or his counsel when provided by law, shall have access to the information described in paragraph 1 of the present principle.

**Principle 24**

A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

**Principle 25**

A detained or imprisoned person or his counsel shall, subject only to reasonable conditions to ensure security and good order in the place of detention or imprisonment, have the right to request or petition a judicial or other authority for a second medical examination or opinion.

**Principle 26**

The fact that a detained or imprisoned person underwent a medical examination, the name of the physician and the results of such an examination shall be duly recorded. Access to such records shall be ensured. Modalities therefor shall be in accordance with relevant rules of domestic law.

**Principle 27**

Non-compliance with these Principles in obtaining evidence shall be taken into account in determining the admissibility of such evidence against a detained or imprisoned person.

**Principle 28**

A detained or imprisoned person shall have the right to obtain within the limits of available resources, if from public sources, reasonable quantities of educational, cultural and informational material, subject to reasonable conditions to ensure security and good order in the place of detention or imprisonment.

**Principle 29**

1. In order to supervise the strict observance of relevant laws and regulations, places of detention shall be visited regularly by qualified and experienced persons appointed by, and responsible to, a competent authority distinct from the authority directly in charge of the administration of the place of detention or imprisonment.
2. A detained or imprisoned person shall have the right to communicate freely and in full confidentiality with the persons who visit the places of detention or imprisonment in accordance with paragraph 1 of the present principle, subject to reasonable conditions to ensure security and good order in such places.

**Principle 30**

1. The types of conduct of the detained or imprisoned person that constitute disciplinary offences during detention or imprisonment, the description and duration of disciplinary punishment that may be inflicted and the authorities competent to impose such punishment shall be specified by law or lawful regulations and duly published.
2. A detained or imprisoned person shall have the right to be heard before disciplinary action is taken. He shall have the right to bring such action to higher authorities for review.

**Principle 31**

The appropriate authorities shall endeavour to ensure, according to domestic law, assistance when needed to dependent and, in particular, minor members of the families of detained or imprisoned persons and shall devote a particular measure of care to the appropriate custody of children left without supervision.

**Principle 32**

1. A detained person or his counsel shall be entitled at any time to take proceedings according to domestic law before a judicial or other authority to challenge the lawfulness of his detention in order to obtain his release without delay, if it is unlawful.
2. The proceedings referred to in paragraph 1 of the present principle shall be simple and expeditious and at no cost for detained persons without adequate means. The detaining authority shall produce without unreasonable delay the detained person before the reviewing authority.

**Principle 33**

1. A detained or imprisoned person or his counsel shall have the right to make a request or complaint regarding his treatment, in particular in case of torture or other cruel, inhuman or degrading treatment, to the authorities responsible for the administration of the place of detention and to higher authorities and, when necessary, to appropriate authorities vested with reviewing or remedial powers.
2. In those cases where neither the detained or imprisoned person nor his counsel has the possibility to exercise his rights under paragraph 1 of the present principle, a member of the family of the detained or imprisoned person or any other person who has knowledge of the case may exercise such rights.
3. Confidentiality concerning the request or complaint shall be maintained if so requested by the complainant.
4. Every request or complaint shall be promptly dealt with and replied to without undue delay. If the request or complaint is rejected or, in case of inordinate delay, the complainant shall be entitled to bring it before a judicial or other authority. Neither the detained or imprisoned person nor any complainant under paragraph 1 of the present principle shall suffer prejudice for making a request or complaint.

**Principle 34**

Whenever the death or disappearance of a detained or imprisoned person occurs during his detention or imprisonment, an inquiry into the cause of death or disappearance shall be held by a judicial or other authority, either on its own motion or at the instance of a member of the family of such a person or any person who has knowledge of the case. When circumstances so warrant, such an inquiry shall be held on the same procedural basis whenever the death or disappearance occurs shortly after the termination of the detention or imprisonment. The findings of such inquiry or a report thereon shall be made available upon request, unless doing so would jeopardize an ongoing criminal investigation.

**Principle 35**

1. Damage incurred because of acts or omissions by a public official contrary to the rights contained in these Principles shall be compensated according to the applicable rules on liability provided by domestic law.

2. Information required to be recorded under these Principles shall be available in accordance with procedures provided by domestic law for use in claiming compensation under the present principle.

### **Principle 36**

1. A detained person suspected of or charged with a criminal offence shall be presumed innocent and shall be treated as such until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

2. The arrest or detention of such a person pending investigation and trial shall be carried out only for the purposes of the administration of justice on grounds and under conditions and procedures specified by law. The imposition of restrictions upon such a person which are not strictly required for the purpose of the detention or to prevent hindrance to the process of investigation or the administration of justice, or for the maintenance of security and good order in the place of detention shall be forbidden.

### **Principle 37**

A person detained on a criminal charge shall be brought before a judicial or other authority provided by law promptly after his arrest. Such authority shall decide without delay upon the lawfulness and necessity of detention. No person may be kept under detention pending investigation or trial except upon the written order of such an authority. A detained person shall, when brought before such an authority, have the right to make a statement on the treatment received by him while in custody.

### **Principle 38**

A person detained on a criminal charge shall be entitled to trial within a reasonable time or to release pending trial.

### **Principle 39**

Except in special cases provided for by law, a person detained on a criminal charge shall be entitled, unless a judicial or other authority decides otherwise in the interest of the administration of justice, to release pending trial subject to the conditions that may be imposed in accordance with the law. Such authority shall keep the necessity of detention under review.

### **General clause**

Nothing in this Body of Principles shall be construed as restricting or derogating from any right defined in the International Covenant on Civil and Political Rights.

Adopted by General Assembly resolution 43/173 of 9 December 1988.  
Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp36.htm](http://www.unhchr.ch/html/menu3/b/h_comp36.htm)

## BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS

*(United Nations General Assembly, 1990)*

1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.
2. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. It is, however, desirable to respect the religious beliefs and cultural precepts of the group to which prisoners belong, whenever local conditions so require.
4. The responsibility of prisons for the custody of prisoners and for the protection of society against crime shall be discharged in keeping with a State's other social objectives and its fundamental responsibilities for promoting the well-being and development of all members of society.
5. Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants.
6. All prisoners shall have the right to take part in cultural activities and education aimed at the full development of the human personality.
7. Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged.
8. Conditions shall be created enabling prisoners to undertake meaningful remunerated employment which will facilitate their reintegration into the country's labour market and permit them to contribute to their own financial support and to that of their families.
9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.
10. With the participation and help of the community and social institutions, and with due regard to the interests of victims, favourable conditions shall be created for the reintegration of the ex-prisoner into society under the best possible conditions.
11. The above Principles shall be applied impartially.

G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp35.htm](http://www.unhchr.ch/html/menu3/b/h_comp35.htm)

## RULES FOR THE PROTECTION OF JUVENILES DEPRIVED OF THEIR LIBERTY

*(United Nations, 1990)*

### FUNDAMENTAL PERSPECTIVES

1. The juvenile justice system should uphold the rights and safety and promote the physical and mental well-being of juveniles. Imprisonment should be used as a last resort.
2. Juveniles should only be deprived of their liberty in accordance with the principles and procedures set forth in these Rules and in the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules). Deprivation of the liberty of a juvenile should be a disposition of last resort and for the minimum necessary period and should be limited to exceptional cases. The length of the sanction should be determined by the judicial authority, without precluding the possibility of his or her early release.
3. The Rules are intended to establish minimum standards accepted by the United Nations for the protection of juveniles deprived of their liberty in all forms, consistent with human rights and fundamental freedoms, and with a view to counteracting the detrimental effects of all types of detention and to fostering integration in society.
4. The Rules should be applied impartially, without discrimination of any kind as to race, colour, sex, age, language, religion, nationality, political or other opinion, cultural beliefs or practices, property, birth or family status, ethnic or social origin, and disability. The religious and cultural beliefs, practices and moral concepts of the juvenile should be respected.
5. The Rules are designed to serve as convenient standards of reference and to provide encouragement and guidance to professionals involved in the management of the juvenile justice system.
6. The Rules should be made readily available to juvenile justice personnel in their national languages. Juveniles who are not fluent in the language spoken by the personnel of the detention facility should have the right to the services of an interpreter free of charge whenever necessary, in particular during medical examinations and disciplinary proceedings.
7. Where appropriate, States should incorporate the Rules into their legislation or amend it accordingly and provide effective remedies for their breach, including compensation when injuries are inflicted on juveniles. States should also monitor the application of the Rules.
8. The competent authorities should constantly seek to increase the awareness of the public that the care of detained juveniles and preparation for their return to society is a social service of great importance, and to this end active steps should be taken to foster open contacts between the juveniles and the local community.
9. Nothing in the Rules should be interpreted as precluding the application of the relevant United Nations and human rights instruments and standards, recognized

by the international community, that are more conducive to ensuring the rights, care and protection of juveniles, children and all young persons.

**10.** In the event that the practical application of particular Rules contained in sections II to V, inclusive, presents any conflict with the Rules contained in the present section, compliance with the latter shall be regarded as the predominant requirement.

## **II. SCOPE AND APPLICATION OF THE RULES**

**11.** For the purposes of the Rules, the following definitions should apply:

- a.** A juvenile is every person under the age of 18. The age limit below which it should not be permitted to deprive a child of his or her liberty should be determined by law;
- b.** The deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting, from which this person is not permitted to leave at will, by order of any judicial, administrative or other public authority.

**12.** The deprivation of liberty should be effected in conditions and circumstances which ensure respect for the human rights of juveniles. Juveniles detained in facilities should be guaranteed the benefit of meaningful activities and programmes which would serve to promote and sustain their health and self-respect, to foster their sense of responsibility and encourage those attitudes and skills that will assist them in developing their potential as members of society.

**13.** Juveniles deprived of their liberty shall not for any reason related to their status be denied the civil, economic, political, social or cultural rights to which they are entitled under national or international law, and which are compatible with the deprivation of liberty.

**14.** The protection of the individual rights of juveniles with special regard to the legality of the execution of the detention measures shall be ensured by the competent authority, while the objectives of social integration should be secured by regular inspections and other means of control carried out, according to international standards, national laws and regulations, by a duly constituted body authorized to visit the juveniles and not belonging to the detention facility.

**15.** The Rules apply to all types and forms of detention facilities in which juveniles are deprived of their liberty. Sections I, II, IV and V of the Rules apply to all detention facilities and institutional settings in which juveniles are detained, and section III applies specifically to juveniles under arrest or awaiting trial.

**16.** The Rules shall be implemented in the context of the economic, social and cultural conditions prevailing in each Member State.

## **III. JUVENILES UNDER ARREST OR AWAITING TRIAL**

**17.** Juveniles who are detained under arrest or awaiting trial (“untried”) are presumed innocent and shall be treated as such. Detention before trial shall be avoided to the extent possible and limited to exceptional circumstances. Therefore, all efforts shall be made to apply alternative measures. When preventive detention

is nevertheless used, juvenile courts and investigative bodies shall give the highest priority to the most expeditious processing of such cases to ensure the shortest possible duration of detention. Untried detainees should be separated from convicted juveniles.

**18.** The conditions under which an untried juvenile is detained should be consistent with the rules set out below, with additional specific provisions as are necessary and appropriate, given the requirements of the presumption of innocence, the duration of the detention and the legal status and circumstances of the juvenile. These provisions would include, but not necessarily be restricted to, the following:

- a. Juveniles should have the right of legal counsel and be enabled to apply for free legal aid, where such aid is available, and to communicate regularly with their legal advisers. Privacy and confidentiality shall be ensured for such communications;
- b. Juveniles should be provided, where possible, with opportunities to pursue work, with remuneration, and continue education or training, but should not be required to do so. Work, education or training should not cause the continuation of the detention;
- c. Juveniles should receive and retain materials for their leisure and recreation as are compatible with the interests of the administration of justice.

#### **IV. THE MANAGEMENT OF JUVENILE FACILITIES**

##### **A. Records**

**19.** All reports, including legal records, medical records and records of disciplinary proceedings, and all other documents relating to the form, content and details of treatment, should be placed in a confidential individual file, which should be kept up to date, accessible only to authorized persons and classified in such a way as to be easily understood. Where possible, every juvenile should have the right to contest any fact or opinion contained in his or her file so as to permit rectification of inaccurate, unfounded or unfair statements. In order to exercise this right, there should be procedures that allow an appropriate third party to have access to and to consult the file on request. Upon release, the records of juveniles shall be sealed, and, at an appropriate time, expunged.

**20.** No juvenile should be received in any detention facility without a valid commitment order of a judicial, administrative or other public authority. The details of this order should be immediately entered in the register. No juvenile should be detained in any facility where there is no such register.

##### **B. Admission, registration, movement and transfer**

**21.** In every place where juveniles are detained, a complete and secure record of the following information should be kept concerning each juvenile received:

- a. Information on the identity of the juvenile;
- b. The fact of and reasons for commitment and the authority therefore;
- c. The day and hour of admission, transfer and release;

- d. Details of the notifications to parents and guardians on every admission, transfer or release of the juvenile in their care at the time of commitment;
  - e. Details of known physical and mental health problems, including drug and alcohol abuse.
- 22.** The information on admission, place, transfer and release should be provided without delay to the parents and guardians or closest relative of the juvenile concerned.
- 23.** As soon as possible after reception, full reports and relevant information on the personal situation and circumstances of each juvenile should be drawn up and submitted to the administration.
- 24.** On admission, all juveniles shall be given a copy of the rules governing the detention facility and a written description of their rights and obligations in a language they can understand, together with the address of the authorities competent to receive complaints, as well as the address of public or private agencies and organizations which provide legal assistance. For those juveniles who are illiterate or who cannot understand the language in the written form, the information should be conveyed in a manner enabling full comprehension.
- 25.** All juveniles should be helped to understand the regulations governing the internal organization of the facility, the goals and methodology of the care provided, the disciplinary requirements and procedures, other authorized methods of seeking information and of making complaints and all such other matters as are necessary to enable them to understand fully their rights and obligations during detention.
- 26.** The transport of juveniles should be carried out at the expense of the administration in conveyances with adequate ventilation and light, in conditions that should in no way subject them to hardship or indignity. Juveniles should not be transferred from one facility to another arbitrarily.

### **C. Classification and placement**

- 27.** As soon as possible after the moment of admission, each juvenile should be interviewed, and a psychological and social report identifying any factors relevant to the specific type and level of care and programme required by the juvenile should be prepared. This report, together with the report prepared by a medical officer who has examined the juvenile upon admission, should be forwarded to the director for purposes of determining the most appropriate placement for the juvenile within the facility and the specific type and level of care and programme required and to be pursued. When special rehabilitative treatment is required, and the length of stay in the facility permits, trained personnel of the facility should prepare a written, individualized treatment plan specifying treatment objectives and time-frame and the means, stages and delays with which the objectives should be approached.
- 28.** The detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements according to their age, personality, sex and type of offence, as well as mental and physical health, and which ensure their protection from harmful influences and risk situations. The principal criterion for the separation of different categories of juveniles deprived of

their liberty should be the provision of the type of care best suited to the particular needs of the individuals concerned and the protection of their physical, mental and moral integrity and well-being.

**29.** In all detention facilities juveniles should be separated from adults, unless they are members of the same family. Under controlled conditions, juveniles may be brought together with carefully selected adults as part of a special programme that has been shown to be beneficial for the juveniles concerned.

**30.** Open detention facilities for juveniles should be established. Open detention facilities are those with no or minimal security measures. The population in such detention facilities should be as small as possible. The number of juveniles detained in closed facilities should be small enough to enable individualized treatment. Detention facilities for juveniles should be decentralized and of such size as to facilitate access and contact between the juveniles and their families. Small-scale detention facilities should be established and integrated into the social, economic and cultural environment of the community.

#### **D. Physical environment and accommodation**

**31.** Juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity.

**32.** The design of detention facilities for juveniles and the physical environment should be in keeping with the rehabilitative aim of residential treatment, with due regard to the need of the juvenile for privacy, sensory stimuli, opportunities for association with peers and participation in sports, physical exercise and leisure-time activities. The design and structure of juvenile detention facilities should be such as to minimize the risk of fire and to ensure safe evacuation from the premises. There should be an effective alarm system in case of fire, as well as formal and drilled procedures to ensure the safety of the juveniles. Detention facilities should not be located in areas where there are known health or other hazards or risks.

**33.** Sleeping accommodation should normally consist of small group dormitories or individual bedrooms, while bearing in mind local standards. During sleeping hours there should be regular, unobtrusive supervision of all sleeping areas, including individual rooms and group dormitories, in order to ensure the protection of each juvenile. Every juvenile should, in accordance with local or national standards, be provided with separate and sufficient bedding, which should be clean when issued, kept in good order and changed often enough to ensure cleanliness.

**34.** Sanitary installations should be so located and of a sufficient standard to enable every juvenile to comply, as required, with their physical needs in privacy and in a clean and decent manner.

**35.** The possession of personal effects is a basic element of the right to privacy and essential to the psychological well-being of the juvenile. The right of every juvenile to possess personal effects and to have adequate storage facilities for them should be fully recognized and respected. Personal effects that the juvenile does not choose to retain or that are confiscated should be placed in safe custody. An inventory

thereof should be signed by the juvenile. Steps should be taken to keep them in good condition. All such articles and money should be returned to the juvenile on release, except in so far as he or she has been authorized to spend money or send such property out of the facility. If a juvenile receives or is found in possession of any medicine, the medical officer should decide what use should be made of it.

**36.** To the extent possible juveniles should have the right to use their own clothing. Detention facilities should ensure that each juvenile has personal clothing suitable for the climate and adequate to ensure good health, and which should in no manner be degrading or humiliating. Juveniles removed from or leaving a facility for any purpose should be allowed to wear their own clothing.

**37.** Every detention facility shall ensure that every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health and, as far as possible, religious and cultural requirements. Clean drinking water should be available to every juvenile at any time.

#### **E. Education, vocational training and work**

**38.** Every juvenile of compulsory school age has the right to education suited to his or her needs and abilities and designed to prepare him or her for return to society. Such education should be provided outside the detention facility in community schools wherever possible and, in any case, by qualified teachers through programmes integrated with the education system of the country so that, after release, juveniles may continue their education without difficulty. Special attention should be given by the administration of the detention facilities to the education of juveniles of foreign origin or with particular cultural or ethnic needs. Juveniles who are illiterate or have cognitive or learning difficulties should have the right to special education.

**39.** Juveniles above compulsory school age who wish to continue their education should be permitted and encouraged to do so, and every effort should be made to provide them with access to appropriate educational programmes.

**40.** Diplomas or educational certificates awarded to juveniles while in detention should not indicate in any way that the juvenile has been institutionalized.

**41.** Every detention facility should provide access to a library that is adequately stocked with both instructional and recreational books and periodicals suitable for the juveniles, who should be encouraged and enabled to make full use of it.

**42.** Every juvenile should have the right to receive vocational training in occupations likely to prepare him or her for future employment.

**43.** With due regard to proper vocational selection and to the requirements of institutional administration, juveniles should be able to choose the type of work they wish to perform.

**44.** All protective national and international standards applicable to child labour and young workers should apply to juveniles deprived of their liberty.

**45.** Wherever possible, juveniles should be provided with the opportunity to perform remunerated labour, if possible within the local community, as a

complement to the vocational training provided in order to enhance the possibility of finding suitable employment when they return to their communities. The type of work should be such as to provide appropriate training that will be of benefit to the juveniles following release. The organization and methods of work offered in detention facilities should resemble as closely as possible those of similar work in the community, so as to prepare juveniles for the conditions of normal occupational life.

**46.** Every juvenile who performs work should have the right to an equitable remuneration. The interests of the juveniles and of their vocational training should not be subordinated to the purpose of making a profit for the detention facility or a third party. Part of the earnings of a juvenile should normally be set aside to constitute a savings fund to be handed over to the juvenile on release. The juvenile should have the right to use the remainder of those earnings to purchase articles for his or her own use or to indemnify the victim injured by his or her offence or to send it to his or her family or other persons outside the detention facility.

#### **F. Recreation**

**47.** Every juvenile should have the right to a suitable amount of time for daily free exercise, in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided. Adequate space, installations and equipment should be provided for these activities. Every juvenile should have additional time for daily leisure activities, part of which should be devoted, if the juvenile so wishes, to arts and crafts skill development. The detention facility should ensure that each juvenile is physically able to participate in the available programmes of physical education. Remedial physical education and therapy should be offered, under medical supervision, to juveniles needing it.

#### **G. Religion**

**48.** Every juvenile should be allowed to satisfy the needs of his or her religious and spiritual life, in particular by attending the services or meetings provided in the detention facility or by conducting his or her own services and having possession of the necessary books or items of religious observance and instruction of his or her denomination. If a detention facility contains a sufficient number of juveniles of a given religion, one or more qualified representatives of that religion should be appointed or approved and allowed to hold regular services and to pay pastoral visits in private to juveniles at their request. Every juvenile should have the right to receive visits from a qualified representative of any religion of his or her choice, as well as the right not to participate in religious services and freely to decline religious education, counselling or indoctrination.

#### **H. Medical care**

**49.** Every juvenile shall receive adequate medical care, both preventive and remedial, including dental, ophthalmological and mental health care, as well as pharmaceutical products and special diets as medically indicated. All such medical

care should, where possible, be provided to detained juveniles through the appropriate health facilities and services of the community in which the detention facility is located, in order to prevent stigmatization of the juvenile and promote self-respect and integration into the community.

**50.** Every juvenile has a right to be examined by a physician immediately upon admission to a detention facility, for the purpose of recording any evidence of prior ill-treatment and identifying any physical or mental condition requiring medical attention.

**51.** The medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition that may hinder the integration of the juvenile into society. Every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive health care and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms of physical or mental difficulties, should be examined promptly by a medical officer.

**52.** Any medical officer who has reason to believe that the physical or mental health of a juvenile has been or will be injuriously affected by continued detention, a hunger strike or any condition of detention should report this fact immediately to the director of the detention facility in question and to the independent authority responsible for safeguarding the well-being of the juvenile.

**53.** A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

**54.** Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles.

**55.** Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be testers in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.

#### **I. Notification of illness, injury and death**

**56.** The family or guardian of a juvenile and any other person designated by the juvenile have the right to be informed of the state of health of the juvenile on request and in the event of any important changes in the health of the juvenile. The director of the detention facility should notify immediately the family or guardian of the juvenile concerned, or other designated person, in case of death, illness requiring

transfer of the juvenile to an outside medical facility, or a condition requiring clinical care within the detention facility for more than 48 hours. Notification should also be given to the consular authorities of the State of which a foreign juvenile is a citizen.

**57.** Upon the death of a juvenile during the period of deprivation of liberty, the nearest relative should have the right to inspect the death certificate, see the body and determine the method of disposal of the body. Upon the death of a juvenile in detention, there should be an independent inquiry into the causes of death, the report of which should be made accessible to the nearest relative. This inquiry should also be made when the death of a juvenile occurs within six months from the date of his or her release from the detention facility and there is reason to believe that the death is related to the period of detention.

**58.** A juvenile should be informed at the earliest possible time of the death, serious illness or injury of any immediate family member and should be provided with the opportunity to attend the funeral of the deceased or go to the bedside of a critically ill relative.

#### **J. Contacts with the wider community**

**59.** Every means should be provided to ensure that juveniles have adequate communication with the outside world, which is an integral part of the right to fair and humane treatment and is essential to the preparation of juveniles for their return to society. Juveniles should be allowed to communicate with their families, friends and other persons or representatives of reputable outside organizations, to leave detention facilities for a visit to their home and family and to receive special permission to leave the detention facility for educational, vocational or other important reasons. Should the juvenile be serving a sentence, the time spent outside a detention facility should be counted as part of the period of sentence.

**60.** Every juvenile should have the right to receive regular and frequent visits, in principle once a week and not less than once a month, in circumstances that respect the need of the juvenile for privacy, contact and unrestricted communication with the family and the defence counsel.

**61.** Every juvenile should have the right to communicate in writing or by telephone at least twice a week with the person of his or her choice, unless legally restricted, and should be assisted as necessary in order effectively to enjoy this right. Every juvenile should have the right to receive correspondence.

**62.** Juveniles should have the opportunity to keep themselves informed regularly of the news by reading newspapers, periodicals and other publications, through access to radio and television programmes and motion pictures, and through the visits of the representatives of any lawful club or organization in which the juvenile is interested.

#### **K. Limitations of physical restraint and the use of force**

**63.** Recourse to instruments of restraint and to force for any purpose should be prohibited, except as set forth in rule 64 below.

**64.** Instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorized and specified by law and regulation. They should not cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time. By order of the director of the administration, such instruments might be resorted to in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction of property. In such instances, the director should at once consult medical and other relevant personnel and report to the higher administrative authority.

**65.** The carrying and use of weapons by personnel should be prohibited in any facility where juveniles are detained.

#### **L. Disciplinary procedures**

**66.** Any disciplinary measures and procedures should maintain the interest of safety and an ordered community life and should be consistent with the upholding of the inherent dignity of the juvenile and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person.

**67.** All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose. Labour should always be viewed as an educational tool and a means of promoting the self-respect of the juvenile in preparing him or her for return to the community and should not be imposed as a disciplinary sanction. No juvenile should be sanctioned more than once for the same disciplinary infraction. Collective sanctions should be prohibited.

**68.** Legislation or regulations adopted by the competent administrative authority should establish norms concerning the following, taking full account of the fundamental characteristics, needs and rights of juveniles:

- a. Conduct constituting a disciplinary offence;
- b. Type and duration of disciplinary sanctions that may be inflicted;
- c. The authority competent to impose such sanctions;
- d. The authority competent to consider appeals.

**69.** A report of misconduct should be presented promptly to the competent authority, which should decide on it without undue delay. The competent authority should conduct a thorough examination of the case.

**70.** No juvenile should be disciplinarily sanctioned except in strict accordance with the terms of the law and regulations in force. No juvenile should be sanctioned unless he or she has been informed of the alleged infraction in a manner appropriate to the full understanding of the juvenile, and given a proper opportunity of presenting his or her defence, including the right of appeal to a

competent impartial authority. Complete records should be kept of all disciplinary proceedings.

**71.** No juveniles should be responsible for disciplinary functions except in the supervision of specified social, educational or sports activities or in self-government programmes.

#### **M. Inspection and complaints**

**72.** Qualified inspectors or an equivalent duly constituted authority not belonging to the administration of the facility should be empowered to conduct inspections on a regular basis and to undertake unannounced inspections on their own initiative, and should enjoy full guarantees of independence in the exercise of this function. Inspectors should have unrestricted access to all persons employed by or working in any facility where juveniles are or may be deprived of their liberty, to all juveniles and to all records of such facilities.

**73.** Qualified medical officers attached to the inspecting authority or the public health service should participate in the inspections, evaluating compliance with the rules concerning the physical environment, hygiene, accommodation, food, exercise and medical services, as well as any other aspect or conditions of institutional life that affect the physical and mental health of juveniles. Every juvenile should have the right to talk in confidence to any inspecting officer.

**74.** After completing the inspection, the inspector should be required to submit a report on the findings. The report should include an evaluation of the compliance of the detention facilities with the present rules and relevant provisions of national law, and recommendations regarding any steps considered necessary to ensure compliance with them. Any facts discovered by an inspector that appear to indicate that a violation of legal provisions concerning the rights of juveniles or the operation of a juvenile detention facility has occurred should be communicated to the competent authorities for investigation and prosecution.

**75.** Every juvenile should have the opportunity of making requests or complaints to the director of the detention facility and to his or her authorized representative.

**76.** Every juvenile should have the right to make a request or complaint, without censorship as to substance, to the central administration, the judicial authority or other proper authorities through approved channels, and to be informed of the response without delay.

**77.** Efforts should be made to establish an independent office (ombudsman) to receive and investigate complaints made by juveniles deprived of their liberty and to assist in the achievement of equitable settlements.

**78.** Every juvenile should have the right to request assistance from family members, legal counsellors, humanitarian groups or others where possible, in order to make a complaint. Illiterate juveniles should be provided with assistance should they need to use the services of public or private agencies and organizations which provide legal counsel or which are competent to receive complaints.

**N. Return to the community**

**79.** All juveniles should benefit from arrangements designed to assist them in returning to society, family life, education or employment after release. Procedures, including early release, and special courses should be devised to this end.

**80.** Competent authorities should provide or ensure services to assist juveniles in re-establishing themselves in society and to lessen prejudice against such juveniles. These services should ensure, to the extent possible, that the juvenile is provided with suitable residence, employment, clothing, and sufficient means to maintain himself or herself upon release in order to facilitate successful reintegration. The representatives of agencies providing such services should be consulted and should have access to juveniles while detained, with a view to assisting them in their return to the community.

**V. PERSONNEL**

**81.** Personnel should be qualified and include a sufficient number of specialists such as educators, vocational instructors, counsellors, social workers, psychiatrists and psychologists. These and other specialist staff should normally be employed on a permanent basis. This should not preclude part-time or volunteer workers when the level of support and training they can provide is appropriate and beneficial. Detention facilities should make use of all remedial, educational, moral, spiritual, and other resources and forms of assistance that are appropriate and available in the community, according to the individual needs and problems of detained juveniles.

**82.** The administration should provide for the careful selection and recruitment of every grade and type of personnel, since the proper management of detention facilities depends on their integrity, humanity, ability and professional capacity to deal with juveniles, as well as personal suitability for the work.

**83.** To secure the foregoing ends, personnel should be appointed as professional officers with adequate remuneration to attract and retain suitable women and men. The personnel of juvenile detention facilities should be continually encouraged to fulfil their duties and obligations in a humane, committed, professional, fair and efficient manner, to conduct themselves at all times in such a way as to deserve and gain the respect of the juveniles, and to provide juveniles with a positive role model and perspective.

**84.** The administration should introduce forms of organization and management that facilitate communications between different categories of staff in each detention facility so as to enhance cooperation between the various services engaged in the care of juveniles, as well as between staff and the administration, with a view to ensuring that staff directly in contact with juveniles are able to function in conditions favourable to the efficient fulfilment of their duties.

**85.** The personnel should receive such training as will enable them to carry out their responsibilities effectively, in particular training in child psychology, child welfare and international standards and norms of human rights and the rights of the child, including the present Rules. The personnel should maintain and improve

their knowledge and professional capacity by attending courses of in-service training, to be organized at suitable intervals throughout their career.

**86.** The director of a facility should be adequately qualified for his or her task, with administrative ability and suitable training and experience, and should carry out his or her duties on a full-time basis.

**87.** In the performance of their duties, personnel of detention facilities should respect and protect the human dignity and fundamental human rights of all juveniles, in particular, as follows:

- a.** No member of the detention facility or institutional personnel may inflict, instigate or tolerate any act of torture or any form of harsh, cruel, inhuman or degrading treatment, punishment, correction or discipline under any pretext or circumstance whatsoever;
- b.** All personnel should rigorously oppose and combat any act of corruption, reporting it without delay to the competent authorities;
- c.** All personnel should respect the present Rules. Personnel who have reason to believe that a serious violation of the present Rules has occurred or is about to occur should report the matter to their superior authorities or organs vested with reviewing or remedial power;
- d.** All personnel should ensure the full protection of the physical and mental health of juveniles, including protection from physical, sexual and emotional abuse and exploitation, and should take immediate action to secure medical attention whenever required;
- e.** All personnel should respect the right of the juvenile to privacy, and, in particular, should safeguard all confidential matters concerning juveniles or their families learned as a result of their professional capacity;
- f.** All personnel should seek to minimize any differences between life inside and outside the detention facility which tend to lessen due respect for the dignity of juveniles as human beings.

Adopted by General Assembly resolution 45/113 of 14 December 1990.

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp37.htm](http://www.unhchr.ch/html/menu3/b/h_comp37.htm)

## STATEMENT ON BODY SEARCHES OF PRISONERS

*(World Medical Association, 1993, 2005)*

*Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005.*

The prison systems in many countries mandate body cavity searches of prisoners. Such searches, which include rectal and pelvic examination, may be performed when an individual enters the prison population and thereafter whenever the individual is permitted to have personal contact with someone outside the prison

population, or when there is a reason to believe a breach of security or of prison regulations has occurred. For example, when a prisoner is taken to Court for a hearing, or to the hospital for treatment, or to work outside the prison, the prisoner, upon returning to the institution, may be subjected to a body cavity search that will include all body orifices. The purpose of the search is primarily security and/or to prevent contraband, such as weapons or drugs, from entering the prison.

These searches are performed for security reasons and not for medical reasons. Nevertheless, they should not be done by anyone other than a person with appropriate medical training. This non-medical act may be performed by a physician to protect the prisoner from the harm that might result from a search by a non-medically trained examiner. In such a case the physician should explain this to the prisoner. The physician should furthermore explain to the prisoner that the usual conditions of medical confidentiality do not apply during this imposed procedure and that the results of the search will be revealed to the authorities. If a physician is duly mandated by an authority and agrees to perform a body cavity search on a prisoner, the authority should be duly informed that it is necessary for this procedure to be done in a humane manner.

If the search is conducted by a physician, it should not be done by the physician who will also subsequently provide medical care to the prisoner.

The physician's obligation to provide medical care to the prisoner should not be compromised by an obligation to participate in the prison's security system.

The World Medical Association urges all governments and public officials with responsibility for public safety to recognize that such invasive search procedures are serious assaults on a person's privacy and dignity, and they also carry some risk of physical and psychological injury. Therefore, the World Medical Association exhorts that, to the extent feasible without compromising public security,

- Alternate methods be used for routine screening of prisoners, and body cavity searches be used only as a last resort;
- If a body cavity search must be conducted, the responsible public official must ensure that the search is conducted by personnel with sufficient medical knowledge and skills to safely perform the search;
- The same responsible authority ensures that the individual's privacy and dignity be guaranteed.

Finally, the World Medical Association urges all governments and responsible public officials to provide body searches that are performed by a qualified physician whenever warranted by the individual's physical condition. A specific request by a prisoner for a physician shall be respected, so far as possible.

The World Medical Association adopts this statement for the purpose of providing guidance for National Medical Associations as they develop ethical guidelines for their physician members.

## POSITION STATEMENT ON THE NURSE'S ROLE IN THE CARE OF DETAINEES AND PRISONERS

(International Council of Nurses, 1998, 2006)

### ICN POSITION:

The International Council of Nurses (ICN) endorses the United Nations Universal Declaration of Human Rights, 1948 and the Geneva Convention of 1949 and the additional protocols and therefore asserts that:

- Prisoners and detainees have the right to health care and humane treatment.
- We condemn interrogation procedures and any act or behavior harmful to mental and physical health.
- Prisoners and detainees have a right to clear and sufficient information; to refuse treatment or diagnostic procedures; and to die with dignity and in a peaceful manner. Nurses' primary responsibility is to those people who require nursing care[1]. In caring for detainees and prisoners nurses are expected to adhere to ethical principles and the following:
  - Nurses who have knowledge of abuse and maltreatment of detainees and prisoners take appropriate action to safeguard their rights.
  - Nurses employed in prison health services do not assume functions of prison security personnel, such as body searches for the purpose of prison security.
  - Nurses participate in clinical research on prisoners and detainees only with the prisoner or detainee's informed consent.
  - Nurses collaborate with other health professionals and prison authorities to reduce the impact of crowded and unhealthy prison environments on transmission of infectious diseases such HIV/AIDS and tuberculosis.
  - Nurses abstain from using their nursing knowledge and skills in any manner, which violates the rights of detainees and prisoners.
  - Nurses advocate for safe humane treatment of detainees and prisoners including clean water, adequate food and other basic necessities of life.

ICN believes National Nurses Associations (NNAs) and individual nurses should be protected from reprisals related to advocacy for or providing care to detainees and prisoners. Furthermore, NNAs should ensure prison nurses have access to confidential advice, counsel and support.

### BACKGROUND

The United Nations Universal Declaration of Human Rights, 1948, states that everyone is entitled to all the rights and freedoms without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and no one shall be subjected to cruel, inhumane or degrading treatment.

The ethical obligations of health professionals are addressed in the *Principles of Medical Ethics Relevant to the Role of Health Personnel, in the Protection of*

*Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* [2]. These and other instruments such as the Istanbul Protocol[3] make clear that health professionals have a moral duty to protect the physical and mental health of prisoners and detainees.

The *ICN Code of Ethics for Nurses* affirms that nurses have a fundamental responsibility to promote health, to prevent illness, to restore health and to alleviate suffering to all people, including detainees and prisoners. Nurses working in prison systems must observe the *Standard Minimum Rules for the Treatment of Prisoners*[4], which require that health services must be available to prisoners without discrimination.

## REFERENCES

- [1] International Council of Nurses, *ICN Code of Ethics for Nurses*, Geneva, ICN, 2005.
- [2] Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.  
([www.unhchr.ch/html/menu3/b/h](http://www.unhchr.ch/html/menu3/b/h))
- [3] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) Submitted to the United Nations High Commissioner for Human Rights, 9 September 1999.
- [4] United Nations (1955), *Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules*, adopted by the UN, 1955. (Replaces previous ICN Position: *The Nurse's Role in the Care of Detainees and Prisoners*, adopted 1975).

Available online at: <http://www.icn.ch/psdetainees.htm>

# 18/PROFESSIONAL ETHICAL CODES

- International Code of Medical Ethics (World Medical Association, 1949, last revised 2006)
- Declaration of Hawaii (World Psychiatric Association, 1983)
- Madrid Declaration on Ethical Standards for Psychiatric Practice (World Psychiatric Association, 1996, last revised 2005)
- Universal Declaration of Ethical Principles for Psychologists (International Union of Psychological Science, 2008)

## INTERNATIONAL CODE OF MEDICAL ETHICS

*(World Medical Association, 1949-2006)*

*Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006.*

### **Duties of Physicians in General**

A physician shall always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.

A physician shall respect a competent patient's right to accept or refuse treatment.

A physician shall not allow his/her judgment to be influenced by personal profit or unfair discrimination.

A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

A physician shall deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

A physician shall not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.

A physician shall respect the rights and preferences of patients, colleagues, and other health professionals.

A physician shall recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.

A physician shall certify only that which he/she has personally verified.

A physician shall strive to use health care resources in the best way to benefit patients and their community.

A physician shall seek appropriate care and attention if he/she suffers from mental or physical illness.

A physician shall respect the local and national codes of ethics.

### **Duties of Physicians to Patients**

A physician shall always bear in mind the obligation to respect human life.

A physician shall act in the patient's best interest when providing medical care.

A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.

A physician shall respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.

A physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.

A physician shall in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.

A physician shall not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

### **Duties of Physicians to Colleagues**

A physician shall behave towards colleagues as he/she would have them behave towards him/her.

A physician shall NOT undermine the patient-physician relationship of colleagues in order to attract patients.

A physician shall when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

### **DECLARATION OF GENEVA**

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968, the 35th World Medical Assembly, Venice, Italy, October 1983, and the 46th WMA General Assembly, Stockholm, Sweden, September 1994; and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

#### **At the time of being admitted as a member of the medical profession:**

**I solemnly pledge** myself to consecrate my life to the service of humanity;

**I will give** to my teachers the respect and gratitude which is their due;  
**I will practice** my profession with conscience and dignity;  
**The health of my patient** will be my first consideration;  
**I will respect** the secrets that are confided in me, even after the patient has died;  
**I will maintain** by all the means in my power, the honour and the noble traditions of the medical profession;  
**My colleagues** will be my sisters and brothers;  
**I will not permit** considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;  
**I will maintain** the utmost respect for human life;  
**I will not use** my medical knowledge to violate human rights and civil liberties, even under threat;  
*I make these promises solemnly, freely and upon my honour.*

Available online at: <http://www.wma.net/e/policy/c8.htm>

## DECLARATION OF HAWAII

*(World Psychiatric Association, 1983)*

Ever since the dawn of culture, ethics has been an essential part of the healing art. It is the view of the World Psychiatric Association that due conflicting loyalties and expectations of both physicians and patients in contemporary society and the delicate nature of the therapist-patient relationship, high ethical standards are especially important for those involved in the science and practice of psychiatry as a medical speciality. These guidelines have been delineated in order to promote close adherence to those standards and to prevent misuse of psychiatric concepts, knowledge and technology.

Since the psychiatrist is a member of society as well as a practitioner of medicine, he or she must consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal responsibility of every man and woman.

Even though ethical behaviour is based on the individual psychiatrist's conscience and personal judgement, written guidelines are needed to clarify the profession's ethical implications.

Therefore, the General Assembly of the World Psychiatric Association has approved these ethical guidelines for psychiatrists, having in mind the great differences in cultural backgrounds, and in legal, social and economic conditions which exist in various countries of the world. It should be understood that the World Psychiatric Association views these guidelines to be minimal requirements for the ethical standards of the psychiatric profession.

**1.** The aim of psychiatry is to treat mental illness and to promote mental health. To the best of his or her ability, consistent with accepted scientific knowledge and

ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health care personnel, patients and the public.

**2.** Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solitude and respect due to the dignity of all human beings. When the psychiatrist is responsible for treatment given by others he owes them competent supervision and education. Whenever there is a need, or whenever reasonable request is forthcoming from the patient, the psychiatrist should seek another colleague.

**3.** The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, cooperation and mutual responsibility. Such a relationship may not be possible to establish with some patients. In that case, contact should be established with a relative or other person close to the patient. If and when a relationship is established for purposes other than therapeutic, such as forensic psychiatry, its nature must be thoroughly explained to the person concerned.

**4.** The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives and of the possible outcome. This information must be offered in a considerate way and the patient must be given the opportunity to choose between appropriate and available methods.

**5.** No procedure shall be performed nor treatment given against or independent of a patient's own will, unless, because of mental illness, the patient cannot form a judgement as to what is in his or her best interest and without which treatment serious impairment is likely to occur to the patient or others.

**6.** As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy necessary should obtain voluntary consent. The psychiatrist should inform the patient and/or relatives or meaningful others, of the existence of mechanisms of appeal for the detention and for any other complaints related to his or her well-being.

**7.** The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.

**8.** Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary. In these cases, however, the patient should be informed of the breach of confidentiality.

**9.** To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before

presenting a patient to a class and, if possible, also when a case history is released for scientific publication, whereby all reasonable measures must be taken to preserve the dignity and anonymity of the patient and to safeguard the personal reputation of the subject. The patient's participation must be voluntary, after full information has been given of the aim, procedures, risks and inconveniences of a research project and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study. In clinical research every subject must retain and exert all his rights as a patient. For children and other patients who cannot themselves give informed consent, this should be obtained from the legal next-of-kin. Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research program in which he or she participates. This withdrawal, as well as any refusal to enter a program, must never influence the psychiatrist's efforts to help the patient or subject.

**10.** The psychiatrist should stop all therapeutic, teaching or research programs that may evolve contrary to the principles of this Declaration.

Available online at: <http://www.wpanet.org/content/ethics-hawaii.shtml>

## MADRID DECLARATION ON ETHICAL STANDARDS FOR PSYCHIATRIC PRACTICE

*(World Psychiatric Association, 1996, 2002, 2005)*

In 1977, the World Psychiatric Association approved the Declaration of Hawaii which set out ethical guidelines for the practice of psychiatry. The Declaration was updated in Vienna in 1983. To reflect the impact of changing social attitudes and new medical developments on the psychiatric profession, the World Psychiatric Association has once again undertaken a review of ethical standards that should be abided to by all its members and all persons practicing psychiatry.

Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill or infirm, because of a mental disorder or impairment. Although there may be cultural, social and national differences, the need for ethical conduct and continual review of ethical standards is universal.

As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical demands of the speciality of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.

Ethical practice is based on the psychiatrist's individual sense of responsibility to the patient and judgment in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

Psychiatrists should keep in mind at all times the boundaries of the

psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity.

It is in this spirit that the World Psychiatric Association approved at the General Assembly on August 25th, 1996, amended on August 8th 1999 and on August 26th 2002 the following ethical standards that should govern the practice of psychiatrists universally.

- 1.** Psychiatry is a medical discipline concerned with the prevention of mental disorders in the population, the provision of the best possible treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.
- 2.** It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.
- 3.** The patient should be accepted as a partner by right in the therapeutic process. The psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with all relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.
- 4.** When the patient is gravely disabled, incapacitated and/or incompetent to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.
- 5.** When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when psychiatrists are involved in third party situations.
- 6.** Information obtained in the therapeutic relationship is private to the patient and should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or personal benefit. Breach of confidentiality may only be appropriate when required by law (as in obligatory reporting of child abuse) or when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; whenever possible, psychiatrists should first advise the patient about the action to be taken.
- 7.** Research that is not conducted in accordance with the canons of science and that is not scientifically valid is unethical. Research activities should be approved by

an appropriately constituted ethics committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients constitute a particularly vulnerable research population, extra caution should be taken to assess their competence to participate as research subjects and to safeguard their autonomy and their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.

### **GUIDELINES CONCERNING SPECIFIC SITUATIONS**

The World Psychiatric Association Ethics Committee recognizes the need to develop a number of specific guidelines on a number of specific situations. The first five were approved by the General Assembly in Madrid, Spain, on August 25, 1996, the 6 through 8 by the General Assembly in Hamburg, Germany, on August 8, 1999, the 9 through 12 by the General Assembly in Yokohama, Japan, on August 26, 2002, and the 13 through 15 at the General Assembly in Cairo, Egypt, on September 12, 2005.

- 1. Euthanasia:** A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informed decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.
- 2. Torture:** Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.
- 3. Death Penalty:** Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.
- 4. Selection of Sex:** Under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection.
- 5. Organ Transplantation:** The role of the psychiatrist is to clarify the issues surrounding organ donations and to advise on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned. The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters. Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situations of organ transplantation.

**6. Psychiatrists addressing the media:** In all contacts with the media psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and pride, and which reduces stigma and discrimination against them.

An important role of psychiatrists is to advocate for those people who suffer from mental disorders. As the public perception of psychiatrists and psychiatry reflects on patients, psychiatrists shall ensure that in their contact with the media they represent the profession of psychiatry with dignity.

Psychiatrists shall not make announcements to the media about presumed psychopathology on any individuals.

In presenting research findings to the media, psychiatrists shall ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

**7. Psychiatrists and discrimination on ethnic or cultural grounds:** Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.

**8. Psychiatrists and genetic research and counseling:** Research on the genetic bases of mental disorders is rapidly increasing and more people suffering from mental illness are participating in such research.

Psychiatrists involved in genetic research or counseling shall be mindful of the fact that the implication of genetic information are not limited to the individual from whom it was obtained and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned.

Psychiatrist shall therefore ensure that:

- People and families who participate in genetic research do so with a fully informed consent;
- Any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse;
- Care is taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings. Psychiatrists shall only refer people to facilities for diagnostic genetic testing if that facility has:
  - Demonstrated satisfactory quality assurance, procedures for such testing;
  - Adequate and easily accessible resources for genetic counseling.

Genetic counseling with regard to family planning or abortion shall be respectful of the patients' value system, while providing sufficient medical and psychiatric information to aid patients make decisions they consider best for them.

**9. Ethics of Psychotherapy in Medicine:** Medical treatments of any nature should be administered under the provisions of good practice guidelines regarding their indications, effectiveness, safety, and quality control. Psychotherapy, in its broadest sense, is an accepted component of many medical interactions. In a more specific and restricted sense, psychotherapy utilizes techniques involving verbal and non-verbal communication and interaction to achieve specified treatment goals in the care of specific disorders. Psychiatrists providing specific forms of psychotherapy must have appropriate training in such techniques. The general guidelines that apply to any medical treatment also apply to specific forms of psychotherapy in regard to its indications and outcomes, positive or negative. The effectiveness of psychotherapy and its place in a treatment plan are important subjects for both researchers and clinicians.

Psychotherapy by psychiatrists is a form of treatment for mental and other illnesses and emotional problems. The treatment approach utilized is determined in concert by the doctor and patient and/or the patient's family and/or guardians following a careful history and examination employing all relevant clinical and laboratory studies. The approach employed should be specific to the disease and patient's needs and sensitive to personal, familial, religious and cultural factors. It should be based on sound research and clinical wisdom and have the purpose of removing, modifying or retarding symptoms or disturbed patterns of behavior. It should promote positive adaptations including personal growth and development.

Psychiatrists and other clinicians responsible for a patient have to ensure that these guidelines are fully applied. Therefore, the psychiatrist or other delegated qualified clinician should determine the indications for psychotherapy and follow its development. In this context the essential notion is that the treatment is the consequence of a diagnosis and both are medical acts performed to take care of an ill person. These two levels of decisions, interventions and responsibilities are similar to other situations in clinical medicine; however, this does not exclude other interventions such as rehabilitation, which can be administered by non-medical personnel.

- 1.** Like any other treatment in medicine, the prescription of psychotherapy should follow accepted guidelines for obtaining informed consent prior to the initiation of treatment as well as updating it in the course of treatment if goals and objectives of treatment are modified in a significant way.
- 2.** If clinical wisdom, long standing and well-established practice patterns (this takes into consideration cultural and religious issues) and scientific evidence suggest potential clinical benefits to combining medication treatment with psychotherapy this should be brought to the patient's attention and fully discussed.
- 3.** Psychotherapy explores intimate thoughts, emotions and fantasies, and as such may engender intense transference and counter-transference. In a psychotherapy relationship the power is unequally shared between the therapist and patient, and under no circumstances shall the psychotherapist use this relationship to personal advantage or transgress the boundaries established by the professional relationship.

4. At the initiation of psychotherapy, the patient shall be advised that information shared and health records will be kept in confidence except where the patient gives specific informed consent for release of information to third parties, or where a court order may require the production of records. The other exception is where there is a legal requirement to report certain information as in the case of child abuse.

**10. Conflict of Interest in Relationship with Industry:** Although most organizations and institutions, including the WPA, have rules and regulations governing their relationship with industry and donors, individual physicians are often involved in interactions with the pharmaceutical industry, or other granting agencies that could lead to ethical conflict. In these situations psychiatrists should be mindful of and apply the following guidelines.

1. The practitioner must diligently guard against accepting gifts that could have an undue influence on professional work.
2. Psychiatrists conducting clinical trials are under an obligation to disclose to the Ethics Review Board and their research subjects their financial and contractual obligations and benefits related to the sponsor of the study. Every effort should be made to set up review boards composed of researchers, ethicists and community representatives to assure the rights of research subjects are protected.
3. Psychiatrists conducting clinical trials have to ensure that their patients have understood all aspects of the informed consent. The level of education or sophistication of the patient is no excuse for bypassing this commitment. If the patient is deemed incompetent the same rules would apply in obtaining informed consent from the substitute decision maker. Psychiatrists must be cognizant that covert commercial influence on the trial design, promotion of drugs trials without scientific value, breach of confidentiality, and restrictive contractual clauses regarding publication of results may each in different ways encroach upon the freedom of science and scientific information.

**11. Conflicts Arising with Third Party Players:** The obligations of organizations toward shareholders or the administrator regarding maximization of profits and minimization of costs can be in conflict with the principles of good practice. Psychiatrists working in such potentially conflicting environments, should uphold the rights of the patients to receive the best treatment possible.

1. In agreement with the UN Resolution 46/119 of the “Principles for the Protection of Persons with Mental Illness” psychiatrists should oppose discriminatory practices which limit their benefits and entitlements, deny parity, curb the scope of treatment, or limit their access to proper medications for patients with a mental disorder.
2. Professional independence to apply best practice guidelines and clinical wisdom in upholding the welfare of the patient should be the primary considerations for the psychiatrist. It is also the duty of the psychiatrist to protect the patient privacy

and confidentiality as part of preserving the sanctity and healing potential of the doctor-patient relationship.

## **12. Violating the Clinical Boundaries and Trust Between Psychiatrists and**

**Patients:** The psychiatrist-patient relationship may be the only relationship that permits an exploration of the deeply personal and emotional space, as granted by the patient. Within this relationship, the psychiatrist's respect for the humanity and dignity of the patient builds a foundation of trust that is essential for a comprehensive treatment plan. The relationship encourages the patient to explore deeply held strengths, weaknesses, fears, and desires, and many of these might be related to sexuality. Knowledge of these characteristics of the patient places the psychiatrist in a position of advantage that the patient allows on the expectation of trust and respect. Taking advantage of that knowledge by manipulating the patient's sexual fears and desires in order to obtain sexual access is a breach of the trust, regardless of consent. In the therapeutic relationship, consent on the part of the patient is considered vitiated by the knowledge the psychiatrists possess about the patient and by the power differential that vests the psychiatrist with special authority over the patient. Consent under these circumstances will be tantamount to exploitation of the patient.

The latent sexual dynamics inherent in all relationships can become manifest in the course of the therapeutic relationship and if they are not properly handled by the therapist can produce anguish to the patient. This anguish is likely to become more pronounced if seductive statements and inappropriate non-verbal behavior are used by the therapist. Under no circumstances, therefore, should a psychiatrist get involved with a patient in any form of sexual behavior, irrespective of whether this behavior is initiated by the patient or the therapist.

## **13. Protection of the Rights of Psychiatrists:**

- 1.** Psychiatrists need to protect their right to live up to the obligations of their profession and to the expectations the public has of them to treat and to advocate for the welfare of their patients.
- 2.** Psychiatrists ought to have the right to practice their specialty at the highest level of excellence by providing independent assessments of a person's mental condition and by instituting effective treatment and management protocols in accordance to best practices and evidence-based medicine.
- 3.** There are aspects in the history of psychiatry and in present working expectations in some totalitarian political regimes and profit-driven economical systems that increase psychiatrists' vulnerabilities to be abused in the sense of having to acquiesce to inappropriate demands to provide inaccurate psychiatric reports that help the system, but damage the interests of the person being assessed.
- 4.** Psychiatrists also share the stigma of their patients and, similarly, can become victims of discriminatory practices. It should be the right and the obligation of psychiatrists to practice their profession and to advocate for the medical needs and

the social and political rights of their patients without suffering being outcast by the profession, being ridiculed in the media or persecuted.

#### **14. Disclosing the Diagnosis of Alzheimer's Disease (AD) and Other Dementias:**

The AD patient's right to know is now a well established priority, recognised by healthcare professionals. Most patients want all information available and to be actively involved in making decision about treatments. At the same time, patients have the right also not to know if that is their wish. All must be given the opportunity to learn as much or as little as they want to know.

The alteration of patient's cognition makes the ability to make judgements and insight more difficult. Patients with dementia are also often brought by family members which introduces into the doctor-patient relationship a third partner.

Doctors, patients and families who share the responsibilities for fighting and coping with Alzheimer's disease for years all require access to information on the disease, including the diagnosis. In addition to the "patient's right to know", telling the patient has many benefits. Patients and/or families should be told the diagnosis as early as possible in the disease process. Having family (or informal carers) involved in the discussion of the disclosure process is highly beneficial.

The physician should give accurate and reliable information, using simple language. He also should assess the patient's and the family's understanding of the situation. As usual, the bad news should be accompanied by information on a treatment and management plan. Information on physical or speech therapy, support groups, day care centres, and other interventions should be provided. It should also be emphasised that a reorganised family network can alleviate the carer's burden and maintain quality of life as far as possible.

There are some exceptions, some of them transitory, to the disclosure of the diagnosis to a patient with dementia: 1) severe dementia where understanding the diagnosis is unlikely, 2) when a phobia about the condition is likely, or 3) when a patient is severely depressed;

**15. Dual Responsibilities of Psychiatrists:** These situations may arise as part of legal proceedings (i.e. fitness to stand trial, criminal responsibility, dangerousness, testamentary capacity) or other competency related needs, such as for insurance purposes when evaluating claims for benefits, or for employment purposes when evaluating fitness to work or suitability for a particular employment or specific task.

During therapeutic interactions conflicting situations may arise if the physician's knowledge of the patient's condition cannot be kept private or when clinical notes or medical records are part of a larger employment dossier, hence not confidential to the clinical personnel in charge of the case (i.e. the military, correctional systems, medical services for employees of large corporations, treatment protocols paid by third parties).

It is the duty of a psychiatrist confronted with dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the

triangular relationship and the absence of a therapeutic doctor-patient relationship, besides the obligation to report to a third party even if the findings are negative and potentially damaging to the interests of the person under assessment. Under these circumstances, the person may choose not to proceed with the assessment.

Additionally, psychiatrists should advocate for separation of records and for limits to exposure of information such that only elements of information that are essential for purposes of the agency can be revealed.

Available online at: <http://www.wpanet.org/content/madrid-ethic-english.shtml>

## UNIVERSAL DECLARATION OF ETHICAL PRINCIPLES FOR PSYCHOLOGISTS (*International Union of Psychological Science, 2008*)

### PREAMBLE

Ethics is at the core of every discipline. *The Universal Declaration of Ethical Principles for Psychologists* speaks to the common moral framework that guides and inspires psychologists worldwide toward the highest ethical ideals in their professional and scientific work. Psychologists recognize that they carry out their activities within a larger social context. They recognize that the lives and identities of human beings both individually and collectively are connected across generations, and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members. They recognize that adherence to ethical principles in the context of their work contributes to a stable society that enhances the quality of life for all human beings.

The objectives of the Universal Declaration are to provide a moral framework and generic set of ethical principles for psychology organizations worldwide: (a) to evaluate the ethical and moral relevance of their codes of ethics; (b) to use as a template to guide the development or evolution of their codes of ethics; (c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and (d) to speak with a collective voice on matters of ethical concern.

The *Universal Declaration* describes those ethical principles that are based on shared human values. It reaffirms the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail. The description of each principle is followed by the presentation of a list of values that are related to the principle. These lists of values highlight ethical concepts that are valuable for promoting each ethical principle.

The *Universal Declaration* articulates principles and related values that are general and aspirational rather than specific and prescriptive. Application of the principles and values to the development of specific standards of conduct will vary across cultures, and must occur locally or regionally in order to ensure their relevance to local or regional cultures, customs, beliefs, and laws.

The significance of the *Universal Declaration* depends on its recognition and promotion by psychology organizations at national, regional and international levels. Every psychology organization is encouraged to keep this Declaration in mind and, through teaching, education, and other measures to promote respect for, and observance of, the Declaration's principles and related values in the various activities of its members.

## **PRINCIPLE I**

### **Respect for the Dignity of Persons and Peoples**

Respect for the dignity of persons is the most fundamental and universally found ethical principle across geographical and cultural boundaries, and across professional disciplines. It provides the philosophical foundation for many of the other ethical principles put forward by professions. Respect for dignity recognizes the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or other such characteristics. This inherent worth means that all human beings are worthy of equal moral consideration.

All human beings, as well as being individuals, are interdependent social beings that are born into, live in, and are a part of the history and ongoing evolution of their peoples. The different cultures, ethnicities, religions, histories, social structures and other such characteristics of peoples are integral to the identity of their members and give meaning to their lives. The continuity of peoples and cultures over time connects the peoples of today with the peoples of past generations and the need to nurture future generations. As such, respect for the dignity of persons includes moral consideration of and respect for the dignity of peoples.

Respect for the dignity of persons and peoples is expressed in different ways in different communities and cultures. It is important to acknowledge and respect such differences. On the other hand, it also is important that all communities and cultures adhere to moral values that respect and protect their members both as individual persons and as collective peoples.

THEREFORE, psychologists accept as fundamental the Principle of Respect for the Dignity of Persons and Peoples. In so doing, they accept the following related values:

- a. respect for the unique worth and inherent dignity of all human beings;
- b. respect for the diversity among persons and peoples;
- c. respect for the customs and beliefs of cultures, to be limited only when a custom or a belief seriously contravenes the principle of respect for the dignity of persons or peoples or causes serious harm to their well-being;
- d. free and informed consent, as culturally defined and relevant for individuals, families, groups, and communities;
- e. privacy for individuals, families, groups, and communities;
- f. protection of confidentiality of personal information, as culturally defined and relevant for individuals, families, groups, and communities;
- g. fairness and justice in the treatment of persons and peoples.

## PRINCIPLE II

### Competent Caring for the Well-Being of Persons and Peoples

Competent caring for the well-being of persons and peoples involves working for their benefit and, above all, doing no harm. It includes maximizing benefits, minimizing potential harm, and offsetting or correcting harm. Competent caring requires the application of knowledge and skills that are appropriate for the nature of a situation as well as the social and cultural context. It also requires the ability to establish interpersonal relationships that enhance potential benefits and reduce potential harm. Another requirement is adequate self-knowledge of how one's values, experiences, culture, and social context might influence one's actions and interpretations.

THEREFORE, psychologists accept as fundamental the Principle of Competent Caring for the Well-Being of Persons and Peoples. In so doing, they accept the following related values:

- a. active concern for the well-being of individuals, families, groups, and communities;
- b. taking care to do no harm to individuals, families, groups, and communities;
- c. maximizing benefits and minimizing potential harm to individuals, families, groups, and communities;
- d. correcting or offsetting harmful effects that have occurred as a result of their activities;
- e. developing and maintaining competence;
- f. self-knowledge regarding how their own values, attitudes, experiences, and social contexts influence their actions, interpretations, choices, and recommendations;
- g. respect for the ability of individuals, families, groups, and communities to make decisions for themselves and to care for themselves and each other.

## PRINCIPLE III

### Integrity

Integrity is vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. Integrity is based on honesty, and on truthful, open and accurate communications. It includes recognizing, monitoring, and managing potential biases, multiple relationships, and other conflicts of interest that could result in harm and exploitation of persons or peoples.

Complete openness and disclosure of information must be balanced with other ethical considerations, including the need to protect the safety or confidentiality of persons and peoples, and the need to respect cultural expectations.

Cultural differences exist regarding appropriate professional boundaries, multiple relationships, and conflicts of interest. However, regardless of such differences, monitoring and management are needed to ensure that self-interest does not interfere with acting in the best interests of persons and peoples.

THEREFORE, psychologists accept as fundamental the Principle of Integrity. In so doing, they accept the following related values:

- a. honesty, and truthful, open and accurate communications;
- b. avoiding incomplete disclosure of information unless complete disclosure is culturally inappropriate, or violates confidentiality, or carries the potential to do serious harm to individuals, families, groups, or communities;
- c. maximizing impartiality and minimizing biases;
- d. not exploiting persons or peoples for personal, professional, or financial gain;
- e. avoiding conflicts of interest and declaring them when they cannot be avoided or are inappropriate to avoid.

## **PRINCIPLE IV**

### **Professional and Scientific Responsibilities to Society**

Psychology functions as a discipline within the context of human society. As a science and a profession, it has responsibilities to society. These responsibilities include contributing to the knowledge about human behavior and to persons' understanding of themselves and others, and using such knowledge to improve the condition of individuals, families, groups, communities, and society. They also include conducting its affairs within society in accordance with the highest ethical standards, and encouraging the development of social structures and policies that benefit all persons and peoples.

Differences exist in the way these responsibilities are interpreted by psychologists in different cultures. However, they need to be considered in a way that is culturally appropriate and consistent with the ethical principles and related values of this Declaration.

THEREFORE, psychologists accept as fundamental the Principle of Professional and Scientific Responsibilities to Society. In so doing, they accept the following related values:

- a. the discipline's responsibility to increase scientific and professional knowledge in ways that allow the promotion of the well-being of society and all its members;
- b. the discipline's responsibility to use psychological knowledge for beneficial purposes and to protect such knowledge from being misused, used incompetently, or made useless;
- c. the discipline's responsibility to conduct its affairs in ways that are ethical and consistent with the promotion of the well-being of society and all its members;
- d. the discipline's responsibility to promote the highest ethical ideals in the scientific, professional and educational activities of its members;
- e. the discipline's responsibility to adequately train its members in their ethical responsibilities and required competencies;
- f. the discipline's responsibility to develop its ethical awareness and sensitivity, and to be as self-correcting as possible.

Available online at: <http://www.am.org/iupsys/ethics/univdecl2008.html>

# 19/RIGHT TO HEALTH

- Declaration of Alma-Ata (International Conference on Primary Health Care, 1978)
- Statement on Access to Health Care (World Medical Association, 1988, last revised 2006)
- General Comment No. 14: The Right to the Highest Attainable Standard of Health (Committee on Economic, Social and Cultural Rights 2000)
- Montreal Statement on the Human Right to Essential Medicines (2005)
- Constitution of the World Health Organization (2006)

## DECLARATION OF ALMA-ATA

*(International Conference on Primary Health Care, 1978)*

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

### DECLARATION:

**I**

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

**II**

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

**III**

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

**IV**

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

**V**

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

**VI**

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

**VII**

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry,

food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

**5.** requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

**6.** should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

**7.** relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

## **VIII**

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

## **IX**

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

## **X**

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding

agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries.

The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Available online at: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

## STATEMENT ON ACCESS TO HEALTH CARE

*(World Medical Association, 1988, 2006)*

Adopted by the 40th World Medical Assembly Vienna, Austria, September 1988 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.

### PREAMBLE

1. The Constitution of the World Health Organization states that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...” Access to health care is a multi-dimensional concept that involves a balancing of factors within the practical constraints of a specific country’s resources and capabilities. The factors include health human resources, financing, transportation, freedom of choice, public education, quality, and allocation of technology.

### GUIDELINES

#### Health Human Resources

2. National Medical Associations should join with other concerned groups from both the private and public sectors to address issues related to the supply and distribution of health human resources. Data should be collected to assess supply and distribution and determine the appropriate mix of health professionals and health workers that can effectively meet the needs of the population. Special efforts should be made to attract physicians and allied health care providers to underserved geographic areas through a variety of incentives and programs. Punitive or coercive models should not be employed. Looking ahead to long-term needs, incentives should also be created to attract medical school students who wish to work in regions where there are health human resource shortages.

#### Financing

3. A pluralistic financing system should be developed that contains elements of both public and private funding. The exact mix of financing may vary significantly from country to country. The system should be based on standards of uniform eligibility and benefits, and it should include adequate payment mechanisms for this purpose. These mechanisms should be clearly explained to the public so that

all concerned understand the payment options available to them. Where appropriate, incentives should be provided for those in the private sector to provide care to patients who otherwise would not have access to it. No one who needs care should be denied it because of inability to pay. Society has an obligation to provide a reasonable subsidy for care of the needy, and physicians have an obligation to participate to a reasonable degree in such subsidized care. Governments have an obligation to ensure that such plans are administered fairly and objectively.

### **Transportation**

4. Society has an obligation to provide adequate access to medical facilities for patients who live in remote areas. Transportation should also be provided to isolated rural patients who require a sophisticated level of care that can be found only in metropolitan medical centres. Telemedicine can sometimes be an acceptable substitute for transportation of patients.

### **Freedom of Choice**

5. All health care delivery systems should provide each individual with the greatest possible personal freedom of choice in selecting a physician. To promote informed personal choice, adequate information concerning both private and public sector options should be made available to the public, employers and other payers of health care.

### **Public Education**

6. Educational programs that assist people in making informed choices about their personal health and about the appropriate uses of both self-care and professional care should be established. These programs should include information about the costs and benefits associated with alternative courses of treatment; the use of professional services that permit early detection and treatment or prevention of illnesses; personal responsibilities in preventing illnesses; and the effective use of the health care system. Patients should be given access to, and retain, copies of their own medical records.

7. In local communities, it is important that the public understand health care plans designed for their benefit and how these plans affect everyone concerned. Physicians have an obligation to actively participate in such educational efforts.

### **Quality**

8. Quality assurance mechanisms should be part of every system of health care delivery. Physicians, in particular, should accept a responsibility for being guardians for the quality of medical care and should not allow other considerations to jeopardize the quality of care provided.

### **Allocation of Technology**

9. Guidelines should be developed for the allocation of scarce health care technologies in order to meet the needs of all patients and health care practitioners

and to ensure the fair and equitable allocation of technology and resources across the health care sector.

## CONCLUSION

10. Access is maximized when the following conditions exist:
  - a. Adequate medical care is available to every individual, regardless of ability to pay.
  - b. There is maximum freedom of choice of health care providers and payment systems to accommodate the diverse needs of the population.
  - c. The entire population has easy access to adequate and comprehensive information on health care providers.
  - d. There is adequate opportunity for active participation by all parties in healthcare systems design and administration.
  - e. Physicians are provided with transparent and efficient ethical criteria for working in overcrowded health systems that endanger health care.
  - f. Medical associations promote equal access to health care, both locally and nationally, through dialogue and common activities with health authorities.

Available online at: <http://www.wma.net/e/policy/a6.htm>

## GENERAL COMMENT NO. 14 – THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH (ARTICLE 12 OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS)

*(Committee on Economic, Social and Cultural Rights, 2000)*

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)
2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services”. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, while article 12.2 enumerates, by way of illustration, a number of “steps to be taken by the States parties ... to

achieve the full realization of this right". Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. (3)

**3.** The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

**4.** In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and 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.

**5.** The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

**6.** With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

## I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

- a.** Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)
- b.** Accessibility. Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
- i.** Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)
  - ii.** Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
  - iii.** Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
  - iv.** Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
- c.** Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

d. Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

*Article 12.2 (a). The right to maternal, child and reproductive health*

14. “The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

*Article 12.2 (b). The right to healthy natural and workplace environments*

15. “The improvement of all aspects of environmental and industrial hygiene” (art. 12.2 (b)) comprises, *inter alia*, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population’s exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

*Article 12.2 (c). The right to prevention, treatment and control of diseases*

16. “The prevention, treatment and control of epidemic, endemic, occupational and other diseases” (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States’ individual and joint efforts to, *inter alia*, make available

relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

*Article 12.2 (d). The right to health facilities, goods and services (15)*

**17.** “The creation of conditions which would assure to all medical service and medical attention in the event of sickness” (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

## **Article 12. Special topics of broad application**

### **Non-discrimination and equal treatment**

**18.** By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

**19.** With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

### **Gender perspective**

**20.** The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

### **Women and the right to health**

**21.** To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important 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.

### **Children and adolescents**

**22.** Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants confidentiality and privacy and includes appropriate sexual and reproductive health services. (17)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

**23.** States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the

right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

**24.** In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

#### **Older persons**

**25.** With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

#### **Persons with disabilities**

**26.** The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

#### **Indigenous peoples**

**27.** In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. 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. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

### **Limitations**

**28.** Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

**29.** In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

## **II. STATES PARTIES' OBLIGATIONS**

### **General legal obligations**

**30.** While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

**31.** The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. (21)

**32.** As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

**33.** The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the

obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

### **Specific legal obligations**

**34.** In particular, States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. (24)

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

**35.** Obligations to protect include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional

practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

**36.** The obligation to fulfil requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

**37.** The obligation to fulfil (facilitate) requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its

obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

### **International obligations**

**38.** In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

**39.** To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

**40.** States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe

and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

**41.** States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

**42.** While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society – individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector – have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

### **Core obligations**

**43.** In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the *Programme of Action of the International Conference on Population and Development*, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following 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.

**44.** The Committee also confirms that the following are obligations of comparable priority:

- 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.

**45.** For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide “international assistance and cooperation, especially economic and technical” (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

### **III. VIOLATIONS**

**46.** When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

**47.** In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

**48.** Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through acts of commission include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

**49.** Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through acts of omission include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

#### **Violations of the obligation to respect**

**50.** Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of *de jure* or *de facto* discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

#### **Violations of the obligation to protect**

**51.** Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

### **Violations of the obligation to fulfil**

**52.** Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

## **IV. IMPLEMENTATION AT THE NATIONAL LEVEL**

### **Framework legislation**

**53.** The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

**54.** The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

**55.** The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

**56.** States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

#### **Right to health indicators and benchmarks**

**57.** National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

**58.** Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

#### **Remedies and accountability**

**59.** Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. (30) All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

**60.** The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

**61.** Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

**62.** States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

#### **V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES**

**63.** The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

**64.** Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

**65.** The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and

management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Adopted on 11 May 2000.

### Notes

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.
2. In its resolution 1989/11.
3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.
4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).
5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.
6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.
7. See paras. 18 and 19 of this General Comment.
8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.
9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: primary health care typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; secondary health care is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; tertiary health care is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful

for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

**10.** According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

**11.** Prenatal denotes existing or occurring before birth; perinatal refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); neonatal, by contrast, covers the period pertaining to the first four weeks after birth; while post-natal denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

**12.** Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

**13.** The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: “Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being”, as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

**14.** ILO Convention No. 155, art. 4.2.

**15.** See para. 12 (b) and note 8 above.

**16.** For the core obligations, see paras. 43 and 44 of the present General Comments.

**17.** Article 24.1 of the Convention on the Rights of the Child.

**18.** See World Health Assembly resolution WHA47.10, 1994, entitled “Maternal and child health and family planning: traditional practices harmful to the health of women and children”.

**19.** Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to

Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

- 20.** See General Comment No. 13, para. 43.
- 21.** See General Comment No. 3, para. 9; General Comment No. 13, para. 44.
- 22.** See General Comment No. 3, para. 9; General Comment No. 13, para. 45.
- 23.** According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to facilitate and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere.
- 24.** General Assembly resolution 46/119 (1991).
- 25.** Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).
- 26.** Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.
- 27.** See para. 45 of this General Comment.
- 28.** Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.
- 29.** Covenant, art. 2.1.
- 30.** Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.
- 31.** See General Comment No. 2, para. 9.

Available online at:

[http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En)

## MONTRÉAL STATEMENT ON THE HUMAN RIGHT TO ESSENTIAL MEDICINES

(2005)

On September 30 – October 2, 2005, a group of individuals drawn from civil society organizations, governments, international agencies, and academic institutions came together in Montréal, Québec, Canada, for an international workshop entitled “Human Rights and Access to Essential Medicines: The Way Forward.” At the conclusion of the workshop, they drafted the “Montréal Statement on the Human Right to Essential Medicines.”

### **Saving lives**

1. Two billion people lack access to essential medicines. This deprivation causes immense suffering: pain, fear, loss of dignity and life. Forty thousand people die daily as a result, the vast majority of them children under five years old.
2. Poor people lack access to essential medicines because research and development do not address their priority health needs, because health systems are inadequate, and because existing medicines are unaffordable to them.
3. This situation is contrary to ethical and legal duties, including human-rights obligations. Existing policies, rules, and institutions foreseeably give rise to deprivations on a massive scale. Alternative designs are feasible; reforms are urgently required. We have a responsibility to achieve a social and international order in which human rights – including the right to essential medicines – are fully realized. This obligation must be recognised and reflected in the design of institutions and policies. On the national and global levels, policies, rules, and institutions must be conducive to the realization of the right to essential medicines. At a minimum, trade agreements, intellectual property laws, loans, aid, and other international arrangements as well as national institutions, laws, and policies must be designed so as to avoid violation of this right.
4. States Parties to international human-rights treaties have a core obligation to respect, protect, and fulfill the right to essential medicines. This core obligation requires immediate and effective measures and is not subject to progressive implementation. Despite many resolutions and statements of commitment in recent years, far too little has been accomplished toward the effective realization of the right to health, including the right to essential medicines. In view of the enormous and persistent suffering and loss of life and health due to lack of access to essential medicines, and the risk of outbreak of new pandemics, the world’s peoples and governments must dedicate themselves to the full realization of this right.

### **Assuring access to existing treatments**

5. The essential medicines covered by this right are those that satisfy the priority health care needs of the population, in light of their public health relevance, proven quality, efficacy and safety, and comparative cost-effectiveness. The Essential Drugs

List provided by the World Health Organization is a model policy guide for the national determination of drugs and other health goods deemed essential for the population of each country.

**6.** The implementation, monitoring and evaluation of national medicines policies must be based on the principle of equitable access to basic services for all and the objective of the highest attainable standard of health. “Highest attainable,” in this context, refers not to a theoretical upper limit of human functioning, but rather to what could be achieved through improvements in product development and health system performance, overcoming of political and economic barriers and better utilization of available resources, including international assistance and cooperation. Accordingly, the national list of essential medicines should be constantly updated to meet the evolving needs of the population. The process of establishing and updating national medicine policies must be participatory: it should include meaningful involvement of professional associations, patient and consumer groups, nongovernmental organizations, and representatives of rural communities and vulnerable groups. It must also provide mechanisms of transparency and accountability through clearly defined objectives, benchmarks and indicators, regular monitoring and evaluation, and procedures for redress and appeal, including judicial remedies, in case the system is too slow or fails to provide essential medicines.

**7.** The human right to essential medicines requires that national health systems guarantee at all times that the population receive all essential medicines in adequate amounts, of assured quality, at the appropriate time and in the appropriate dosage. Those who receive the medicines must be adequately informed and consent to the treatment. The essential drugs made available must be at a price the individual and the community can afford.

#### **Overcoming political and economic barriers**

**8.** Social and economic conditions determine population health. Moreover, they are vital to access to medicines. As a result, realizing the right to essential medicines requires a strategy to strengthen health systems, including sufficient and adequately trained health personnel and eliminating poverty and social disparities.

**9.** The responsibility of governments for the fulfilment of human rights includes international assistance and cooperation. Affluent countries must, therefore, ensure fairer trade and investment, eliminate crippling debt, and contribute equitably to international assistance aimed at facilitating the full realization of the right to essential medicines.

**10.** All governments have the duty, through their voice and vote in international financial, monetary and trade institutions and development agencies, and in their bilateral development policies and programmes, to ensure that the human right to essential medicines is furthered in the lending, trade and aid policies of those institutions and agencies.

**11.** States are entitled and obliged to take all reasonable and feasible steps to enable access to essential medicines, including adopting trade practices and using

trade flexibilities and safeguards, such as compulsory licensing and parallel importing. All States must abstain from measures – including political interference and trade pressures – that hamper the implementation of such flexibilities and safeguards, or otherwise impede access to medicines.

**12.** The responsibilities for the elimination of poverty are shared by the less affluent countries. Poverty reduction strategies must be participatory, transparent, and focused on the most vulnerable segments of the population. Measures and policies to reduce poverty must be compatible with States' human rights obligations, including the human right to essential medicines.

**13.** International institutions and their member states have a duty to respect and actively promote health as a human right. Accordingly, they must ensure that international agreements relating to the protection of intellectual property do not result in violation of the human right to essential medicines. On the national and global levels, all policy decisions or agreements likely to have a significant effect on health should be preceded by a transparent and independent health impact assessment. All parties to the decision or agreement are obligated to minimise foreseeable negative impacts on health identified by such assessment.

#### **Health innovation as a global public good**

**14.** The price of patented medicines is a major barrier to the realization of the human right to share in scientific advancement and its benefits, including innovations in essential medicines. The only justification for pharmaceutical patents is the stimulation of innovation. However, the present incentive system results in high consumer prices and in millions of people being denied the right to affordable medicines. This system also leads to a skewing of research priorities, driven by return on investment rather than priority health needs and outcomes.

**15.** Governments must, therefore, adopt and implement alternative innovation systems that ensure that research and development are sufficient to meet priority health needs. Among these alternatives are international commitments to funding health research as a global public good, and schemes that reward innovation based on health outcomes. Such alternative innovation systems must be designed to prioritize the right to essential medicines.

Available online at:

[http://www.economyandsociety.org/events/Pogge\\_background\\_paper2.pdf](http://www.economyandsociety.org/events/Pogge_background_paper2.pdf)

## CONSTITUTION OF THE WORLD HEALTH ORGANIZATION<sup>1</sup>

*(Basic Documents, Forty-fifth edition, Supplement, 2006)*

This text replaces that on pages 1–18 of the Forty-fifth edition of Basic documents, following the coming into force of amendments adopted by the Fifty-first World Health Assembly.

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

---

1. The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2,100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively and are incorporated in the present text.

## CHAPTER I – OBJECTIVE

### Article 1

The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health.

## CHAPTER II – FUNCTIONS

### Article 2

In order to achieve its objective, the functions of the Organization shall be:

- a. to act as the directing and co-ordinating authority on international health work;
- b. to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;
- c. to assist Governments, upon request, in strengthening health services;
- d. to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;
- e. to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;
- f. to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
- g. to stimulate and advance work to eradicate epidemic, endemic and other diseases;
- h. to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;
- i. to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;
- j. to promote co-operation among scientific and professional groups which contribute to the advancement of health;
- k. to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;
- l. to promote maternal and child health and welfare and to foster the ability to live harmoniously in changing total environment;
- m. to foster activities in the field of mental health, especially those affecting the harmony of human relations;
- n. to promote and conduct research in the field of health;
- o. to promote improved standards of teaching and training in the health, medical and related professions;
- p. to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health

and medical care from preventive and curative points of view, including hospital services and social security;

- q. to provide information, counsel and assistance in the field of health;
- r. to assist in developing an informed public opinion among all peoples on matters of health;
- s. to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;
- t. to standardize diagnostic procedures as necessary;
- u. to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;
- v. generally to take all necessary action to attain the objective of the Organization.

### **CHAPTER III – MEMBERSHIP AND ASSOCIATE MEMBERSHIP**

#### **Article 3**

Membership in the Organization shall be open to all States.

#### **Article 4**

Members of the United Nations may become Members of the Organization by signing or otherwise accepting this Constitution in accordance with the provisions of Chapter XIX and in accordance with their constitutional processes.

#### **Article 5**

The States whose Governments have been invited to send observers to the International Health Conference held in New York, 1946, may become Members by signing or otherwise accepting this Constitution in accordance with the provisions of Chapter XIX and in accordance with their constitutional processes provided that such signature or acceptance shall be completed before the first session of the Health Assembly.

#### **Article 6**

Subject to the conditions of any agreement between the United Nations and the Organization, approved pursuant to Chapter XVI, States which do not become Members in accordance with Articles 4 and 5 may apply to become Members and shall be admitted as Members when their application has been approved by a simple majority vote of the Health Assembly.

#### **Article 7<sup>2</sup>**

If a Member fails to meet its financial obligations to the Organization or in other exceptional circumstances, the Health Assembly may, on such conditions as it

---

2. The amendment to this Article adopted by the Eighteenth World Health Assembly (resolution WHA18.48) has not yet come into force.

thinks proper, suspend the voting privileges and services to which a Member is entitled. The Health Assembly shall have the authority to restore such voting privileges and services.

#### **Article 8**

Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as Associate Members by the Health Assembly upon application made on behalf of such territory or group of territories by the Member or other authority having responsibility for their international relations. Representatives of Associate Members to the Health Assembly should be qualified by their technical competence in the field of health and should be chosen from the native population. The nature and extent of the rights and obligations of Associate Members shall be determined by the Health Assembly.

### **CHAPTER IV – ORGANS**

#### **Article 9**

The work of the Organization shall be carried out by:

- a. The World Health Assembly (herein called the Health Assembly);
- b. The Executive Board (hereinafter called the Board);
- c. The Secretariat.

### **CHAPTER V – THE WORLD HEALTH ASSEMBLY**

#### **Article 10**

The Health Assembly shall be composed of delegates representing Members.

#### **Article 11**

Each Member shall be represented by not more than three delegates, one of whom shall be designated by the Member as chief delegate. These delegates should be chosen from among persons most qualified by their technical competence in the field of health, preferably representing the national health administration of the Member.

#### **Article 12**

Alternates and advisers may accompany delegates.

#### **Article 13**

The Health Assembly shall meet in regular annual session and in such special sessions as may be necessary. Special sessions shall be convened at the request of the Board or of a majority of the Members.

#### **Article 14**

The Health Assembly, at each annual session, shall select the country or region in which the next annual session shall be held, the Board subsequently fixing the place. The Board shall determine the place where a special session shall be held.

**Article 15**

The Board, after consultation with the Secretary-General of the United Nations, shall determine the date of each annual and special session.

**Article 16**

The Health Assembly shall elect its President and other officers at the beginning of each annual session. They shall hold office until their successors are elected.

**Article 17**

The Health Assembly shall adopt its own rules of procedure.

**Article 18**

The functions of the Health Assembly shall be:

- a. to determine the policies of the Organization;
- b. to name the Members entitled to designate a person to serve on the Board;
- c. to appoint the Director-General;
- d. to review and approve reports and activities of the Board and of the Director-General and to instruct the Board in regard to matters upon which action, study, investigation or report may be considered desirable;
- e. to establish such committees as may be considered necessary for the work of the Organization;
- f. to supervise the financial policies of the Organization and to review and approve the budget;
- g. to instruct the Board and the Director-General to bring to the attention of Members and of international organizations, governmental or nongovernmental, any matter with regard to health which the Health Assembly may consider appropriate;
- h. to invite any organization, international or national, governmental or nongovernmental, which has responsibilities related to those of the Organization, to appoint representatives to participate, without right of vote, in its meetings or in those of the committees and conferences convened under its authority, on conditions prescribed by the Health Assembly; but in the case of national organizations, invitations shall be issued only with the consent of the Government concerned;
- i. to consider recommendations bearing on health made by the General Assembly, the Economic and Social Council, the Security Council or Trusteeship Council of the United Nations, and to report to them on the steps taken by the Organization to give effect to such recommendations;
- j. to report to the Economic and Social Council in accordance with any agreement between the Organization and the United Nations;
- k. to promote and conduct research in the field of health by the personnel of the Organization, by the establishment of its own institutions or by co-

operation with official or non-official institutions of any Member with the consent of its Government;

- l.** to establish such other institutions as it may consider desirable;
- m.** to take any other appropriate action to further the objective of the Organization.

### **Article 19**

The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization.

A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

### **Article 20**

Each Member undertakes that it will, within eighteen months after the adoption by the Health Assembly of a convention or agreement, take action relative to the acceptance of such convention or agreement. Each Member shall notify the Director-General of the action taken, and if it does not accept such convention or agreement within the time limit, it will furnish a statement of the reasons for non-acceptance. In case of acceptance, each Member agrees to make an annual report to the Director-General in accordance with Chapter XIV.

### **Article 21**

The Health Assembly shall have authority to adopt regulations concerning:

- a.** sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
- b.** nomenclatures with respect to diseases, causes of death and public health practices;
- c.** standards with respect to diagnostic procedures for international use;
- d.** standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
- e.** advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

### **Article 22**

Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice.

### **Article 23**

The Health Assembly shall have authority to make recommendations to Members with respect to any matter within the competence of the Organization.

## **CHAPTER VI – THE EXECUTIVE BOARD**

### **Article 24**

The Board shall consist of thirty-four persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established pursuant to Article 44. Each of these Members should appoint to the Board a person technically qualified in the field of health, who may be accompanied by alternates and advisers.

### **Article 25**

These Members shall be elected for three years and may be re-elected, provided that of the Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty-two to thirty-four the term of office of the additional Members elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one Member from each regional organization in each year.

### **Article 26**

The Board shall meet at least twice a year and shall determine the place of each meeting.

### **Article 27**

The Board shall elect its Chairman from among its members and shall adopt its own rules of procedure.

### **Article 28**

The functions of the Board shall be:

- a. to give effect to the decisions and policies of the Health Assembly;
- b. to act as the executive organ of the Health Assembly;
- c. to perform any other functions entrusted to it by the Health Assembly;
- d. to advise the Health Assembly on questions referred to it by that body and on matters assigned to the Organization by conventions, agreements and regulations;
- e. to submit advice or proposals to the Health Assembly on its own initiative;
- f. to prepare the agenda of meetings of the Health Assembly;
- g. to submit to the Health Assembly for consideration and approval a general programme of work covering a specific period;
- h. to study all questions within its competence;
- i. to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular it may authorize the Director-General to take the necessary steps to combat epidemics, to participate in the organization of health relief to victims of a

calamity and to undertake studies and research the urgency of which has been drawn to the attention of the Board by any Member or by the Director-General.

**Article 29**

The Board shall exercise on behalf of the whole Health Assembly the powers delegated to it by that body.

**CHAPTER VII – THE SECRETARIAT**

**Article 30**

The Secretariat shall comprise the Director-General and such technical and administrative staff as the Organization may require.

**Article 31**

The Director-General shall be appointed by the Health Assembly on the nomination of the Board on such terms as the Health Assembly may determine. The Director-General, subject to the authority of the Board, shall be the chief technical and administrative officer of the Organization.

**Article 32**

The Director-General shall be *ex-officio* Secretary of the Health Assembly, of the Board, of all commissions and committees of the Organization and of conferences convened by it. He may delegate these functions.

**Article 33**

The Director-General or his representative may establish a procedure by agreement with Members, permitting him, for the purpose of discharging his duties, to have direct access to their various departments, especially to their health administrations and to national health organizations, governmental or non-governmental. He may also establish direct relations with international organizations whose activities come within the competence of the Organization. He shall keep regional offices informed on all matters involving their respective areas.

**Article 34**

The Director-General shall prepare and submit to the Board the financial statements and budget estimates of the Organization.

**Article 35**

The Director-General shall appoint the staff of the Secretariat in accordance with staff regulations established by the Health Assembly. The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible.

**Article 36**

The conditions of service of the staff of the Organization shall conform as far as possible with those of other United Nations organizations.

**Article 37**

In the performance of their duties the Director-General and the staff shall not seek or receive instructions from any government or from any authority external to the Organization. They shall refrain from any action which might reflect on their position as international officers. Each Member of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them.

**CHAPTER VIII – COMMITTEES****Article 38**

The Board shall establish such committees as the Health Assembly may direct and, on its own initiative or on the proposal of the Director-General, may establish any other committees considered desirable to serve any purpose within the competence of the Organization.

**Article 39**

The Board, from time to time and in any event annually, shall review the necessity for continuing each committee.

**Article 40**

The Board may provide for the creation of or the participation by the Organization in joint or mixed committees with other organizations and for the representation of the Organization in committees established by such other organizations.

**CHAPTER IX – CONFERENCES****Article 41**

The Health Assembly or the Board may convene local, general, technical or other special conferences to consider any matter within the competence of the Organization and may provide for the representation at such conferences of international organizations and, with the consent of the Government concerned, of national organizations, governmental or nongovernmental. The manner of such representation shall be determined by the Health Assembly or the Board.

**Article 42**

The Board may provide for representation of the Organization at conferences in which the Board considers that the Organization has an interest.

**CHAPTER X – HEADQUARTERS****Article 43**

The location of the headquarters of the Organization shall be determined by the Health Assembly after consultation with the United Nations.

## CHAPTER XI – REGIONAL ARRANGEMENTS

### Article 44

- a. The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.
- b. The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.

### Article 45

Each regional organization shall be an integral part of the Organization in accordance with this Constitution.

### Article 46

Each regional organization shall consist of a regional committee and a regional office.

### Article 47

Regional committees shall be composed of representatives of the Member States and Associate Members in the region concerned. Territories or groups of territories within the region, which are not responsible for the conduct of their international relations and which are not Associate Members, shall have the right to be represented and to participate in regional committees. The nature and extent of the rights and obligations of these territories or groups of territories in regional committees shall be determined by the Health Assembly in consultation with the Member or other authority having responsibility for the international relations of these territories and with the Member States in the region.

### Article 48

Regional committees shall meet as often as necessary and shall determine the place of each meeting.

### Article 49

Regional committees shall adopt their own rules of procedure.

### Article 50

The functions of the regional committee shall be:

- a. to formulate policies governing matters of an exclusively regional character;
- b. to supervise the activities of the regional office;
- c. to suggest to the regional office the calling of technical conferences and such additional work or investigation in health matters as in the opinion of the regional committee would promote the objective of the Organization within the region;

- d. to co-operate with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;
- e. to tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;
- f. to recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions;
- g. such other functions as may be delegated to the regional committee by the Health Assembly, the Board or the Director-General.

#### **Article 51**

Subject to the general authority of the Director-General of the Organization, the regional office shall be the administrative organ of the regional committee. It shall, in addition, carry out within the region the decisions of the Health Assembly and of the Board.

#### **Article 52**

The head of the regional office shall be the Regional Director appointed by the Board in agreement with the regional committee.

#### **Article 53**

The staff of the regional office shall be appointed in a manner to be determined by agreement between the Director-General and the Regional Director.

#### **Article 54**

The Pan American Sanitary Organization<sup>3</sup> represented by the Pan American Sanitary Bureau and the Pan American Sanitary Conferences, and all other inter-governmental regional health organizations in existence prior to the date of signature of this Constitution, shall in due course be integrated with the Organization. This integration shall be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned.

### **CHAPTER XII – BUDGET AND EXPENSES**

#### **Article 55**

The Director-General shall prepare and submit to the Board the budget estimates of the Organization. The Board shall consider and submit to the Health Assembly such budget estimates, together with any recommendations the Board may deem advisable.

---

3. Renamed “Pan American Health Organization” by decision of the XV Pan American Sanitary Conference, September–October 1958.

**Article 56**

Subject to any agreement between the Organization and the United Nations, the Health Assembly shall review and approve the budget estimates and shall apportion the expenses among the Members in accordance with a scale to be fixed by the Health Assembly.

**Article 57**

The Health Assembly or the Board acting on behalf of the Health Assembly may accept and administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable to the Health Assembly or the Board and are consistent with the objective and policies of the Organization.

**Article 58**

A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies.

**CHAPTER XIII – VOTING****Article 59**

Each Member shall have one vote in the Health Assembly.

**Article 60**

- a. Decisions of the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and inter-governmental organizations and agencies in accordance with Articles 69, 70 and 72; amendments to this Constitution.
- b. Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the Members present and voting.
- c. Voting on analogous matters in the Board and in committees of the Organization shall be made in accordance with paragraphs (a) and (b) of this Article.

**CHAPTER XIV – REPORTS SUBMITTED BY STATES****Article 61**

Each Member shall report annually to the Organization on the action taken and progress achieved in improving the health of its people.

**Article 62**

Each Member shall report annually on the action taken with respect to recommendations made to it by the Organization and with respect to conventions, agreements and regulations.

**Article 63**

Each Member shall communicate promptly to the Organization important laws, regulations, official reports and statistics pertaining to health which have been published in the State concerned.

**Article 64**

Each Member shall provide statistical and epidemiological reports in a manner to be determined by the Health Assembly.

**Article 65**

Each Member shall transmit upon the request of the Board such additional information pertaining to health as may be practicable.

**CHAPTER XV – LEGAL CAPACITY, PRIVILEGES AND IMMUNITIES****Article 66**

The Organization shall enjoy in the territory of each Member such legal capacity as may be necessary for the fulfilment of its objective and for the exercise of its functions.

**Article 67**

- a. The Organization shall enjoy in the territory of each Member such privileges and immunities as may be necessary for the fulfilment of its objective and for the exercise of its functions.
- b. Representatives of Members, persons designated to serve on the Board and technical and administrative personnel of the Organization shall similarly enjoy such privileges and immunities as are necessary for the independent exercise of their functions in connexion with the Organization.

**Article 68**

Such legal capacity, privileges and immunities shall be defined in a separate agreement to be prepared by the Organization in consultation with the Secretary-General of the United Nations and concluded between the Members.

**CHAPTER XVI – RELATIONS WITH OTHER ORGANIZATIONS****Article 69**

The Organization shall be brought into relation with the United Nations as one of the specialized agencies referred to in Article 57 of the Charter of the United Nations. The agreement or agreements bringing the Organization into relation with the United Nations shall be subject to approval by a two-thirds vote of the Health Assembly.

**Article 70**

The Organization shall establish effective relations and co-operate closely with such other inter-governmental organizations as may be desirable. Any formal agreement

entered into with such organizations shall be subject to approval by a two-thirds vote of the Health Assembly.

#### **Article 71**

The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental.

#### **Article 72**

Subject to the approval by a two-thirds vote of the Health Assembly, the Organization may take over from any other international organization or agency whose purpose and activities lie within the field of competence of the Organization such functions, resources and obligations as may be conferred upon the Organization by international agreement or by mutually acceptable arrangements entered into between the competent authorities of the respective organizations.

### **CHAPTER XVII – AMENDMENTS**

#### **Article 73**

Texts of proposed amendments to this Constitution shall be communicated by the Director-General to Members at least six months in advance of their consideration by the Health Assembly. Amendments shall come into force for all Members when adopted by a two-thirds vote of the Health Assembly and accepted by two-thirds of the Members in accordance with their respective constitutional processes.

### **CHAPTER XVIII – INTERPRETATION**

#### **Article 74**

The Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic.

#### **Article 75**

Any question or dispute concerning the interpretation or application of this Constitution which is not settled by negotiation or by the Health Assembly shall be referred to the International Court of Justice in conformity with the Statute of the Court, unless the parties concerned agree on another mode of settlement.

#### **Article 76**

Upon authorization by the General Assembly of the United Nations or upon authorization in accordance with any agreement between the Organization and the United Nations, the Organization may request the International Court of Justice for an advisory opinion on any legal question arising within the competence of the Organization.

**Article 77**

The Director-General may appear before the Court on behalf of the Organization in connexion with any proceedings arising out of any such request for an advisory opinion. He shall make arrangements for the presentation of the case before the Court, including arrangements for the argument of different views on the question.

**CHAPTER XIX – ENTRY-INTO-FORCE****ARTICLE 78**

Subject to the provisions of Chapter III, this Constitution shall remain open to all States for signature or acceptance.

**Article 79**

- a. States may become parties to this Constitution by:
  - i. signature without reservation as to approval;
  - ii. signature subject to approval followed by acceptance; or
  - iii. acceptance.
- b. Acceptance shall be effected by the deposit of a formal instrument with the Secretary-General of the United Nations.

**Article 80**

This Constitution shall come into force when twenty-six Members of the United Nations have become parties to it in accordance with the provisions of Article 79.

**Article 81**

In accordance with Article 102 of the Charter of the United Nations, the Secretary-General of the United Nations will register this Constitution when it has been signed without reservation as to approval on behalf of one State or upon deposit of the first instrument of acceptance.

**Article 82**

The Secretary-General of the United Nations will inform States parties to this Constitution of the date when it has come into force. He will also inform them of the dates when other States have become parties to this Constitution.

IN FAITH WHEREOF the undersigned representatives, having been duly authorized for that purpose, sign this Constitution.

DONE in the City of New York this twenty-second day of July 1946, in a single copy in the Chinese, English, French, Russian and Spanish languages, each text being equally authentic. The original texts shall be deposited in the archives of the United Nations. The Secretary-General of the United Nations will send certified copies to each of the Governments represented at the Conference.

# 20/SEXUAL AND REPRODUCTIVE RIGHTS

- Declaration on Therapeutic Abortion (World Medical Association, 1970, last revised 2006)
- Statement on Family Planning and the Right of a Woman to Contraception (World Medical Association, 1996, last revised 2007)
- Resolution on Women's Rights Related to Reproductive and Sexual Health (International Federation of Gynecology and Obstetrics, 2000)
- Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights (International Federation of Gynecology and Obstetrics, 2003)
- Resolution on Women's Sexual and Reproductive Rights – A Social Responsibility for Obstetricians and Gynaecologists (International Federation of Gynecology and Obstetrics, 2003)

## DECLARATION ON THERAPEUTIC ABORTION

*(World Medical Association, 1970, 1983, 2006)*

1. The WMA requires the physician to maintain respect for human life.
2. Circumstances bringing the interests of a mother into conflict with the interests of her unborn child create a dilemma and raise the question as to whether or not the pregnancy should be deliberately terminated.
3. Diversity of responses to such situations is due in part to the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience that must be respected.
4. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the physician within society.
5. Therefore, where the law allows therapeutic abortion to be performed, the procedure should be performed by a physician competent to do so in premises approved by the appropriate authority.
6. If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague.

Available online at: <http://www.wma.net/e/policy/a1.htm>

## STATEMENT ON FAMILY PLANNING AND THE RIGHT OF A WOMAN TO CONTRACEPTION

*(World Medical Association, 1996, 2007)*

- The WMA recognizes that unwanted pregnancies and pregnancies that are too closely spaced can have a serious adverse effect on the health of a woman and of her children. These adverse effects can include the premature deaths of women. Existing children in the family can also suffer starvation, neglect or abandonment resulting in their death or impaired health, when families are unable to provide for all their children. Social functioning and the ability to reach their full potential can also be impaired.
- The WMA recognizes the benefits for women who are able to control their fertility. They should be helped to make such choices themselves, as well as in discussion with their partners. The ability to do so by choice and not chance is a principal component of women's physical and mental health and social well being.
- Access to adequate fertility control methods is not universal; many of the poorest women in the world have the least access. Knowledge about how their bodies work, information on how to control their fertility and the materials necessary to make those choices are universal and basic human rights for all women.
- The role of family planning and secure access to appropriate methods is recognized in the 5th Millennium Development goal as a major factor promoting maternal and child health.
- The WMA recommends that National Medical Associations:
  - Promote family planning education by working with governments, NGOs and others to provide secure and high-quality services and assistance.
  - Attempt to ensure that such information, materials, products and services are available without regard to nationality, creed, race, religion or socioeconomic status.

Available online at: <http://www.wma.net/e/policy/c13.htm>

## RESOLUTION ON WOMEN'S RIGHTS RELATED TO REPRODUCTIVE AND SEXUAL HEALTH

*(International Federation of Gynecology and Obstetrics, 2000)*

**Affirming** that improvements in women's health need more than better science and health care; they require state action to correct injustices to women.

**Recognising** that women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights.

**Recognising** that when states have ratified human rights conventions they have legal obligations to implement them.

**Noting** that human rights are inalienable rights inherent to human dignity.

**Upholding** the principle declared by the 1993 World Conference on Human Rights

that the human rights of girls and women are an inalienable and indivisible part of human rights, to be protected not only in courts, prisons and other areas of public life but also in the privacy of the home.

**Noting** that international human rights law has focused too exclusively on the public arena and neglected the private sphere of home, family and community in which women are traditionally enclosed.

**Noting** that women suffer the same indignities and breaches of their human rights as men; in addition, they are vulnerable to particular gender-based violations relating to their reproductive function and the way societies limit their role and potential.

### **The FIGO General Assembly**

**Affirms** its support for women in their struggle to claim and regain their basic human rights.

**Expresses** its commitment to collaborate with other organisations at the national, regional and international level, including the United Nations system, to further advance these rights.

**Confirms** that sexual and reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

**Underscores** that states have an obligation to protect women's right to the highest attainable standard of health and bring forward plans for the attainment of this right that are based on an objective and reliable assessment of the magnitude of the burden of disease on women.

**Declares** that violence against women, in all its forms including sexual violence, is not just a health and social problem; it is a violation of women's basic right to freedom from torture and ill treatment, their right to liberty and security of the person, and their right to physical integrity.

**States** that while the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. It is unacceptable that the international community remains passive when women's rights, particularly those related to sexual and reproductive health, are violated.

**Urges** all states to ratify and implement the Convention on the Elimination of All forms of Discrimination Against women, to report to its Committee on the Elimination of Discrimination Against Women (CEDAW) and comply with its recommendations.

**Calls upon FIGO member societies:**

- To make their expertise available to health, educational and legal professional associations and to collaborate with women's and human rights groups to promote a working partnership in order to foster compliance with human rights relating to reproductive and sexual health by:
  - proposing and promoting guidelines for the obstetrician/gynecologists for the respect of these rights
  - playing an active role in educating the public, making expertise available to policy makers and legislators about the health dimension of women's rights and their impact on society at large
  - proposing national standards for the respect of these rights.
  - Calls upon all members of the profession to respect and protect women's rights in their daily practice, including their sexual and reproductive rights.

Available online at:

[http://www.figo.org/projects/reproductive\\_and\\_sexual\\_health](http://www.figo.org/projects/reproductive_and_sexual_health)

## PROFESSIONAL AND ETHICAL RESPONSIBILITIES CONCERNING SEXUAL AND REPRODUCTIVE RIGHTS

*(International Federation of Gynecology and Obstetrics, 2003)*

**BACKGROUND:**

**Sexual and reproductive health** is a matter of urgent global concern. The tremendous burden of morbidity and mortality that women experience as a result of their role in reproduction, increased by their unequal social standing, is unacceptably high, yet substantially preventable. The reproductive and sexual health of women is often compromised, not necessarily because of lack of medical knowledge, but rather as a result of basic infringements of women's human rights that also violate the basic and universally agreed upon ethical and professional responsibilities of professionals caring for women.

**Sexual and reproductive health** is also an issue for human development, as women are essential to economic and social stability and progress in all societies. The potential contribution of women is frequently not realized because of limitations on women's human rights, including lack of access to information and safe and appropriate care. The human right to security of the person underpins the medical ethic to treat women respectfully. Professionalism in health care of women is the means by which physicians provide ethical care that respects the sexual and reproductive rights of women.

The inherent power imbalance between women seeking, and physicians providing, health care derives not only from inequality of knowledge, but often from cultural and economic differences. Physicians have a central role and considerable social responsibility in societies as a result of their knowledge and expertise. This status provides them with the means to influence policy makers in social and health

care. It also allows them to highlight inequities in the reproductive and sexual health care of women and to advocate for improved status of women in general.

### **ETHICS AND HUMAN RIGHTS REGARDING SEXUAL AND REPRODUCTIVE HEALTH:**

While human rights are protected by national laws and constitutions and by regional and international treaties, medical ethics are protected by codes monitored primarily by the medical profession. The principles of medical ethics applied to all individuals, such as beneficence (maximize best health outcomes), non-maleficence (do no harm), autonomy (ensure rights of persons to make informed choices about their own health care), and justice, are derived from and consistent with general human rights. The purpose of human rights is to promote human dignity. This translates into the obligation to benefit the patient in the course of health care (in respect both of their mental and physical health) and the commitment to doing no harm. The human rights to the highest attainable standard of health and to the benefits of scientific progress form the basis of the professional commitment to beneficence and justice. The human rights to a private life, to conscience and to liberty and security of the person are also key elements of autonomy that includes the duty to protect confidentiality in health care.

Relationships that underlie sexual and reproductive health are a natural part of life that should be entered into freely and safely, without violence or coercion, for both men and women. The sexual and reproductive rights that arise from human rights in general form an important part of medical ethics and apply to all women regardless of age, marital status, ethnicity, political affiliation, race, religion, economic status, disability, or other status. These rights imply a need to inform public opinion and to promote a respectful public dialogue, including different ethical and religious perspectives and noting that freedom of religion includes the requirement that no one religion or belief can impose its values on others. Thus, member societies must recognize and respect the diversity of cultures and religions that may exist within a country in order to provide culturally sensitive care for all women.

**FIGO member societies** adopt and promote among their members, the following professional responsibilities, based on their commitment to assuring human rights and ethical principles in the reproductive health care of women:

#### **A. Professional Competence:**

- 1. Attain and maintain** the highest standards of professional competence in women's health, utilizing the most current and best available medical evidence within the context of available resources.
- 2. Assure** that professional competence includes offering only services for which one is trained to a recognized standard and referring to suitably skilled professionals as circumstances permit.
- 3. Assure** respectful professional conduct that promotes the dignity and security of every woman.

4. **Avoid** inappropriate relationships with patients or their families, that may be exploited for sexual, emotional, financial, or research purposes.
5. **Assure** that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.
6. **Refuse** to practice, or support practices, that violate human rights or principles of medical ethics.
7. **Maintain and promote** the highest standards of integrity and honesty with patients, colleagues and learners and in the conduct of research.
8. **Model** appropriate interpersonal behavior with patients and others in order to assure that optimal care and learning environments are promoted by all members of the health care team.
9. **Advocate** for life long learning for health care professionals in regard to reproductive and sexual health, rights, and ethics.

#### **B. Women's Autonomy and Confidentiality:**

1. **Support** a decision-making process, free from bias or coercion, which allows women to make informed choices regarding their sexual and reproductive health. This includes the need to act only on the basis of a fully informed consent or dissent, based on adequate provision of information and education to the patient regarding the nature, management implications, options and outcomes of choices. In this way, healthcare professionals provide women with the opportunity to consider and evaluate treatment options in the context of their own life circumstances and culture.
2. **Ensure** that confidentiality will prevent privileged information and recorded documents from being shared verbally or otherwise, except as required by law or desired by the patient.
3. **Adhere** to the principle of non-discrimination in order to assure that every woman is treated respectfully regardless of age, marital status, ethnicity, political affiliation, race, religion, economic status, disability, or other status. Women should be treated with respect for their individual judgment and not that of their partners or family.
4. **Assure** that adolescent women are treated without age discrimination, according to their evolving capacities – rather than merely their chronological age – in facilitating them to make free and informed decisions regarding their sexual and reproductive health.

#### **C. Responsibility to the Community:**

1. **Advocate** for the right of women to have access to the information and education needed to allow them to determine the timing of their reproduction in keeping with the ethical principle of autonomy and the human right to freely choose if and when to have children.

2. **Advocate** for the rights of women to make choices about sexual relationships as a natural part of their lives, assisting them to enter into these relationships freely and safely.
3. **Advocate** for appropriate resources and care for women seeking better reproductive and sexual health to ensure the rights to the highest attainable standard of health and the right to benefit from scientific progress.
4. **Inform** communities about the issues of sexual and reproductive health and rights in order to promote a broad respectful dialogue based on best health evidence in order to influence health practices, policies, and laws.

Although this document is specific to women, the principles articulated within may be equally applied to men.

This document is designed to complement the “*Recommendations on Ethical Issues in Obstetrics and Gynecology*” by the FIGO Committee for the Study of Ethical Aspects of Human Reproduction”. November 2003.

Available online at:

<http://www.sogc.org/guidelines/public/151E-JPS-December2004.pdf>

## RESOLUTION ON WOMEN’S SEXUAL AND REPRODUCTIVE RIGHTS – A SOCIAL RESPONSIBILITY FOR OBSTETRICIANS AND GYNAECOLOGISTS

(*International Federation of Gynecology and Obstetrics, 2003*)

**Recalling** the resolution of the 2000 General Assembly on “Women’s Rights Relating to Reproductive and Sexual Health”

**Recalling** that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. \*

**Re-affirming** that women’s health is often compromised not by lack of medical knowledge, but by infringements on women’s human rights

**Noting** with satisfaction the progress report of the FIGO Committee on Women’s Sexual and Reproductive Rights

**Affirming** that improvements in women’s health worldwide require the advocacy and action of Obstetricians/Gynaecologists

**Acknowledging** that Obstetricians and Gynaecologists are obligated by the special professional privileges granted to them by nations and societies, as well as their unique knowledge, to promote and protect women’s health in their individual and professional encounters

### The FIGO General Assembly:

**Confirms** its commitment to continue to collaborate with other organizations at the national, regional and international level, including the United Nations System, to further advance women’s sexual and reproductive rights

**Declares** that advocacy and inclusion of the human rights of women are an integral and priority area in FIGO activities

**Invites FIGO member societies to:**

**adopt** and adapt a human rights-based code of ethics for women's health, in the professional conduct of all their activities

**work** with educational bodies to incorporate the human rights based code of ethics in the curriculum of all levels of training in obstetrics and gynaecology

**focus** their efforts on priority areas in human rights failings identified in their own countries, where advocacy efforts by gynaecologists and obstetricians, in collaboration with other civil society groups, can have an impact on women's health

**Calls upon all members of the profession to:**

**stand** for women's sexual and reproductive rights in their countries

**respect** and protect women's rights in their daily practice

\* Cairo document para 7.3

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, as expressed in human rights documents.

Available online at: [http://www.figo.org/projects/ethical\\_responsibility](http://www.figo.org/projects/ethical_responsibility)

# 21/TORTURE

- Declaration against Torture (United Nations, 1975)
- Declaration of Tokyo (World Medical Association, 1975, last revised 2006)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 1984)
- Statement of Madrid (Standing Committee on European Doctors, 1989)
- Declaration of Principle – Torture (World Confederation for Physical Therapy, 1995, last revised 2007)
- Plan of Action against Torture (Amnesty International, 1996)
- Declaration of Hamburg Concerning Support for Medical Doctors (World Medical Association, 1997)
- Torture, Death Penalty and Participation by Nurses in Executions (International Council of Nurses, 1998, last revised 2006)
- Principles on the Effective Documentation of Torture (Istanbul Protocol, 1999)
- Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (World Medical Association, 2003, last revised 2007)
- 12-Point Programme for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment by Agents of the State (Amnesty International, 2005)

## DECLARATION AGAINST TORTURE

*(United Nations, 1975)*

### **Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment**

#### **Article 1**

**1.** For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

**2.** Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.

**Article 2**

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.

**Article 3**

No State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

**Article 4**

Each State shall, in accordance with the provisions of this Declaration, take effective measures to prevent torture and other cruel, inhuman or degrading treatment or punishment from being practised within its jurisdiction.

**Article 5**

The training of law enforcement personnel and of other public officials who may be responsible for persons deprived of their liberty shall ensure that full account is taken of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment. This prohibition shall also, where appropriate, be included in such general rules or instructions as are issued in regard to the duties and functions of anyone who may be involved in the custody or treatment of such persons.

**Article 6**

Each State shall keep under systematic review interrogation methods and practices as well as arrangements for the custody and treatment of persons deprived of their liberty in its territory, with a view to preventing any cases of torture or other cruel, inhuman or degrading treatment or punishment.

**Article 7**

Each State shall ensure that all acts of torture as defined in Article 1 are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture.

**Article 8**

Any person who alleges that he has been subjected to torture or other cruel, inhuman or degrading treatment or punishment by or at the instigation of a public official shall have the right to complain to, and to have his case impartially examined by, the competent authorities of the State concerned.

**Article 9**

Wherever there is reasonable ground to believe that an act of torture as defined in Article 1 has been committed, the competent authorities of the State concerned shall promptly proceed to an impartial investigation, even if there has been no formal complaint.

**Article 10**

If an investigation under Article 8 or Article 9 establishes that an act of torture as defined in Article 1 appears to have been committed, criminal proceedings shall be instituted against the alleged offender or offenders in accordance with national law. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings.

**Article 11**

Where it is proved that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed by or at the instigation of a public official, the victim shall be afforded redress and compensation in accordance with national law.

**Article 12**

Any statement which is established to have been made as a result of torture or other cruel, inhuman or degrading treatment or punishment may not be invoked as evidence against the person concerned or against any other person in any proceedings.

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_comp38.htm](http://www.unhchr.ch/html/menu3/b/h_comp38.htm)

**DECLARATION OF TOKYO**

*(World Medical Association, 1975, 2005, 2006)*

**PREAMBLE**

It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

## DECLARATION

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.
4. The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.
5. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.
7. The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

Available online at:  
<http://www.wma.net/e/policy/c18.htm>

# CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

*(United Nations, 1984)*

## **PART 1**

### **Article 1**

1. For the purposes of this Convention, the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.

### **Article 2**

1. Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.

2. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.

3. An order from a superior officer or a public authority may not be invoked as a justification of torture.

### **Article 3**

1. No State Party shall expel, return (“refouler”) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

### **Article 4**

1. Each State Party shall ensure that all acts of torture are offenses under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture.

2. Each State Party shall make these offenses punishable by appropriate penalties which take into account their grave nature.

### **Article 5**

1. Each State Party shall take such measures as may be necessary to establish its jurisdiction over the offences referred to in article 4 in the following cases:
  - a. When the offences are committed in any territory under its jurisdiction or on board a ship or aircraft registered in that State;
  - b. When the alleged offender is a national of that State;
  - c. When the victim is a national of that State if that State considers it appropriate.
2. Each State Party shall likewise take such measures as may be necessary to establish its jurisdiction over such offences in cases where the alleged offender is present in any territory under its jurisdiction and it does not extradite him pursuant to article 8 to any of the States mentioned in paragraph 1 of this article.
3. This Convention does not exclude any criminal jurisdiction exercised in accordance with internal law.

### **Article 6**

1. Upon being satisfied, after an examination of information available to it, that the circumstances so warrant, any State Party in whose territory a person alleged to have committed any offence referred to in article 4 is present shall take him into custody or take other legal measures to ensure his presence. The custody and other legal measures shall be as provided in the law of that State but may be continued only for such time as is necessary to enable any criminal or extradition proceedings to be instituted.
2. Such State shall immediately make a preliminary inquiry into the facts.
3. Any person in custody pursuant to paragraph 1 of this article shall be assisted in communicating immediately with the nearest appropriate representative of the State of which he is a national, or, if he is a stateless person, with the representative of the State where he usually resides.
4. When a State, pursuant to this article, has taken a person into custody, it shall immediately notify the States referred to in article 5, paragraph 1, of the fact that such person is in custody and of the circumstances which warrant his detention. The State which makes the preliminary inquiry contemplated in paragraph 2 of this article shall promptly report its findings to the said States and shall indicate whether it intends to exercise jurisdiction.

### **Article 7**

1. The State Party in the territory under whose jurisdiction a person alleged to have committed any offence referred to in article 4 is found shall in the cases contemplated in article 5, if it does not extradite him, submit the case to its competent authorities for the purpose of prosecution.
2. These authorities shall take their decision in the same manner as in the case of any ordinary offence of a serious nature under the law of that State. In the cases referred to in article 5, paragraph 2, the standards of evidence required for

prosecution and conviction shall in no way be less stringent than those which apply in the cases referred to in article 5, paragraph 1.

3. Any person regarding whom proceedings are brought in connection with any of the offences referred to in article 4 shall be guaranteed fair treatment at all stages of the proceedings.

#### **Article 8**

1. The offences referred to in article 4 shall be deemed to be included as extraditable offences in any extradition treaty existing between States Parties. States Parties undertake to include such offences as extraditable offences in every extradition treaty to be concluded between them.

2. If a State Party which makes extradition conditional on the existence of a treaty receives a request for extradition from another State Party with which it has no extradition treaty, it may consider this Convention as the legal basis for extradition in respect of such offences. Extradition shall be subject to the other conditions provided by the law of the requested State.

3. States Parties which do not make extradition conditional on the existence of a treaty shall recognize such offences as extraditable offences between themselves subject to the conditions provided by the law of the requested State.

4. Such offences shall be treated, for the purpose of extradition between States Parties, as if they had been committed not only in the place in which they occurred but also in the territories of the States required to establish their jurisdiction in accordance with article 5, paragraph 1.

#### **Article 9**

1. States Parties shall afford one another the greatest measure of assistance in connection with criminal proceedings brought in respect of any of the offences referred to in article 4, including the supply of all evidence at their disposal necessary for the proceedings.

2. States Parties shall carry out their obligations under paragraph 1 of this article in conformity with any treaties on mutual judicial assistance that may exist between them.

#### **Article 10**

1. Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

2. Each State Party shall include this prohibition in the rules or instructions issued in regard to the duties and functions of any such persons.

#### **Article 11**

Each State Party shall keep under systematic review interrogation rules, instructions,

methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture.

#### **Article 12**

Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.

#### **Article 13**

Each State Party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill-treatment or intimidation as a consequence of his complaint or any evidence given.

#### **Article 14**

1. Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.
2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

#### **Article 15**

Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made.

#### **Article 16**

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.
2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.

## **PART II**

### **Article 17**

- 1.** There shall be established a Committee against Torture (hereinafter referred to as the Committee) which shall carry out the functions hereinafter provided. The Committee shall consist of ten experts of high moral standing and recognized competence in the field of human rights, who shall serve in their personal capacity. The experts shall be elected by the States Parties, consideration being given to equitable geographical distribution and to the usefulness of the participation of some persons having legal experience.
- 2.** The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals. States Parties shall bear in mind the usefulness of nominating persons who are also members of the Human Rights Committee established under the International Covenant on Civil and Political Rights and who are willing to serve on the Committee against Torture.
- 3.** Elections of the members of the Committee shall be held at biennial meetings of States Parties convened by the Secretary-General of the United Nations. At those meetings, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.
- 4.** The initial election shall be held no later than six months after the date of the entry into force of this Convention. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within three months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.
- 5.** The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. However, the term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these five members shall be chosen by lot by the chairman of the meeting referred to in paragraph 3 of this article.
- 6.** If a member of the Committee dies or resigns or for any other cause can no longer perform his Committee duties, the State Party which nominated him shall appoint another expert from among its nationals to serve for the remainder of his term, subject to the approval of the majority of the States Parties. The approval shall be considered given unless half or more of the States Parties respond negatively within six weeks after having been informed by the Secretary-General of the United Nations of the proposed appointment.
- 7.** States Parties shall be responsible for the expenses of the members of the Committee while they are in performance of Committee duties.

**Article 18**

1. The Committee shall elect its officers for a term of two years. They may be re-elected.
2. The Committee shall establish its own rules of procedure, but these rules shall provide, *inter alia*, that:
  - a. Six members shall constitute a quorum;
  - b. Decisions of the Committee shall be made by a majority vote of the members present.
3. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under this Convention.
4. The Secretary-General of the United Nations shall convene the initial meeting of the Committee. After its initial meeting, the Committee shall meet at such times as shall be provided in its rules of procedure.
5. The States Parties shall be responsible for expenses incurred in connection with the holding of meetings of the States Parties and of the Committee, including reimbursement to the United Nations for any expenses, such as the cost of staff and facilities, incurred by the United Nations pursuant to paragraph 3 of this article. (Amendment (see General Assembly resolution 47/111 of 16 December 1992));

**Article 19**

1. The States Parties shall submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have taken to give effect to their undertakings under this Convention, within one year after the entry into force of the Convention for the State Party concerned. Thereafter the States Parties shall submit supplementary reports every four years on any new measures taken and such other reports as the Committee may request.
2. The Secretary-General of the United Nations shall transmit the reports to all States Parties.
3. Each report shall be considered by the Committee which may make such general comments on the report as it may consider appropriate and shall forward these to the State Party concerned. That State Party may respond with any observations it chooses to the Committee.
4. The Committee may, at its discretion, decide to include any comments made by it in accordance with paragraph 3 of this article, together with the observations thereon received from the State Party concerned, in its annual report made in accordance with article 24. If so requested by the State Party concerned, the Committee may also include a copy of the report submitted under paragraph 1 of this article.

**Article 20**

1. If the Committee receives reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party, the Committee shall invite that State Party to cooperate in the

examination of the information and to this end to submit observations with regard to the information concerned.

- 2.** Taking into account any observations which may have been submitted by the State Party concerned, as well as any other relevant information available to it, the Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently.
- 3.** If an inquiry is made in accordance with paragraph 2 of this article, the Committee shall seek the cooperation of the State Party concerned. In agreement with that State Party, such an inquiry may include a visit to its territory.
- 4.** After examining the findings of its member or members submitted in accordance with paragraph 2 of this article, the Committee shall transmit these findings to the State Party concerned together with any comments or suggestions which seem appropriate in view of the situation.
- 5.** All the proceedings of the Committee referred to in paragraphs 1 to 4 of this article shall be confidential and at all stages of the proceedings the cooperation of the State Party shall be sought. After such proceedings have been completed with regard to an inquiry made in accordance with paragraph 2, the Committee may, after consultations with the State Party concerned, decide to include a summary account of the results of the proceedings in its annual report made in accordance with article 24.

## **Article 21**

- 1.** A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under this Convention. Such communications may be received and considered according to the procedures laid down in this article only if submitted by a State Party which has made a declaration recognizing in regard to itself the competence of the Committee. No communication shall be dealt with by the Committee under this article if it concerns a State Party which has not made such a declaration. Communications received under this article shall be dealt with in accordance with the following procedure;
  - a.** If a State Party considers that another State Party is not giving effect to the provisions of this Convention, it may, by written communication, bring the matter to the attention of that State Party. Within three months after the receipt of the communication the receiving State shall afford the State which sent the communication an explanation or any other statement in writing clarifying the matter, which should include, to the extent possible and pertinent, reference to domestic procedures and remedies taken, pending or available in the matter;
  - b.** If the matter is not adjusted to the satisfaction of both States Parties concerned within six months after the receipt by the receiving State of the initial communication, either State shall have the right to refer the matter to the Committee, by notice given to the Committee and to the other State;

- c. The Committee shall deal with a matter referred to it under this article only after it has ascertained that all domestic remedies have been invoked and exhausted in the matter, in conformity with the generally recognized principles of international law. This shall not be the rule where the application of the remedies is unreasonably prolonged or is unlikely to bring effective relief to the person who is the victim of the violation of this Convention;
- d. The Committee shall hold closed meetings when examining communications under this article;
- e. Subject to the provisions of subparagraph (c), the Committee shall make available its good offices to the States Parties concerned with a view to a friendly solution of the matter on the basis of respect for the obligations provided for in this Convention. For this purpose, the Committee may, when appropriate, set up an ad hoc conciliation commission;
- f. In any matter referred to it under this article, the Committee may call upon the States Parties concerned, referred to in subparagraph (b), to supply any relevant information;
- g. The States Parties concerned, referred to in subparagraph (b), shall have the right to be represented when the matter is being considered by the Committee and to make submissions orally and/or in writing;
- h. The Committee shall, within twelve months after the date of receipt of notice under subparagraph (b), submit a report:
  - i. If a solution within the terms of subparagraph (e) is reached, the Committee shall confine its report to a brief statement of the facts and of the solution reached;
  - ii. If a solution within the terms of subparagraph (e) is not reached, the Committee shall confine its report to a brief statement of the facts; the written submissions and record of the oral submissions made by the States Parties concerned shall be attached to the report.

In every matter, the report shall be communicated to the States Parties concerned.

**2.** The provisions of this article shall come into force when five States Parties to this Convention have made declarations under paragraph 1 of this article. Such declarations shall be deposited by the States Parties with the Secretary-General of the United Nations, who shall transmit copies thereof to the other States Parties. A declaration may be withdrawn at any time by notification to the Secretary-General. Such a withdrawal shall not prejudice the consideration of any matter which is the subject of a communication already transmitted under this article; no further communication by any State Party shall be received under this article after the notification of withdrawal of the declaration has been received by the Secretary-General, unless the State Party concerned has made a new declaration.

## **Article 22**

**1.** A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider

communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the Convention. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration.

**2.** The Committee shall consider inadmissible any communication under this article which is anonymous or which it considers to be an abuse of the right of submission of such communications or to be incompatible with the provisions of this Convention.

**3.** Subject to the provisions of paragraph 2, the Committee shall bring any communications submitted to it under this article to the attention of the State Party to this Convention which has made a declaration under paragraph 1 and is alleged to be violating any provisions of the Convention. Within six months, the receiving State shall submit to the Committee written explanations or statements clarifying the matter and the remedy, if any, that may have been taken by that State.

**4.** The Committee shall consider communications received under this article in the light of all information made available to it by or on behalf of the individual and by the State Party concerned.

**5.** The Committee shall not consider any communications from an individual under this article unless it has ascertained that:

- a.** The same matter has not been, and is not being, examined under another procedure of international investigation or settlement;
- b.** The individual has exhausted all available domestic remedies; this shall not be the rule where the application of the remedies is unreasonably prolonged or is unlikely to bring effective relief to the person who is the victim of the violation of this Convention.

**6.** The Committee shall hold closed meetings when examining communications under this article.

**7.** The Committee shall forward its views to the State Party concerned and to the individual.

**8.** The provisions of this article shall come into force when five States Parties to this Convention have made declarations under paragraph 1 of this article. Such declarations shall be deposited by the States Parties with the Secretary-General of the United Nations, who shall transmit copies thereof to the other States Parties. A declaration may be withdrawn at any time by notification to the Secretary-General. Such a withdrawal shall not prejudice the consideration of any matter which is the subject of a communication already transmitted under this article; no further communication by or on behalf of an individual shall be received under this article after the notification of withdrawal of the declaration has been received by the Secretary General, unless the State Party has made a new declaration.

### **Article 23**

The members of the Committee and of the ad hoc conciliation commissions which may be appointed under article 21, paragraph 1 (e), shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down

in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

#### **Article 24**

The Committee shall submit an annual report on its activities under this Convention to the States Parties and to the General Assembly of the United Nations.

### **PART III**

#### **Article 25**

1. This Convention is open for signature by all States. 2. This Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

#### **Article 26**

This Convention is open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary General of the United Nations.

#### **Article 27**

1. This Convention shall enter into force on the thirtieth day after the date of the deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying this Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

#### **Article 28**

1. Each State may, at the time of signature or ratification of this Convention or accession thereto, declare that it does not recognize the competence of the Committee provided for in article 20.

2. Any State Party having made a reservation in accordance with paragraph 1 of this article may, at any time, withdraw this reservation by notification to the Secretary-General of the United Nations.

#### **Article 29**

1. Any State Party to this Convention may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary General shall thereupon communicate the proposed amendment to the States Parties with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposal. In the event that within four months from the date of such communication at least one third of the States Parties favours such a conference, the Secretary General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States

Parties present and voting at the conference shall be submitted by the Secretary-General to all the States Parties for acceptance.

**2.** An amendment adopted in accordance with paragraph 1 of this article shall enter into force when two thirds of the States Parties to this Convention have notified the Secretary-General of the United Nations that they have accepted it in accordance with their respective constitutional processes.

**3.** When amendments enter into force, they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of this Convention and any earlier amendments which they have accepted.

### **Article 30**

**1.** Any dispute between two or more States Parties concerning the interpretation or application of this Convention which cannot be settled through negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the Parties are unable to agree on the organization of the arbitration, any one of those Parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

**2.** Each State may, at the time of signature or ratification of this Convention or accession thereto, declare that it does not consider itself bound by paragraph 1 of this article. The other States Parties shall not be bound by paragraph 1 of this article with respect to any State Party having made such a reservation.

**3.** Any State Party having made a reservation in accordance with paragraph 2 of this article may at any time withdraw this reservation by notification to the Secretary-General of the United Nations.

### **Article 31**

**1.** A State Party may denounce this Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

**2.** Such a denunciation shall not have the effect of releasing the State Party from its obligations under this Convention in regard to any act or omission which occurs prior to the date at which the denunciation becomes effective, nor shall denunciation prejudice in any way the continued consideration of any matter which is already under consideration by the Committee prior to the date at which the denunciation becomes effective.

**3.** Following the date at which the denunciation of a State Party becomes effective, the Committee shall not commence consideration of any new matter regarding that State.

### **Article 32**

The Secretary-General of the United Nations shall inform all States Members of the United Nations and all States which have signed this Convention or acceded to it of the following:

- a.** Signatures, ratifications and accessions under articles 25 and 26;

- b. The date of entry into force of this Convention under article 27 and the date of the entry into force of any amendments under article 29;
- c. Denunciations under article 31.

### Article 33

1. This Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of this Convention to all States.

Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984, entry into force 26 June 1987, in accordance with article 27 (1) 'status of ratifications'.

Available online at: [http://www.unhchr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhchr.ch/html/menu3/b/h_cat39.htm)

## STATEMENT OF MADRID RECOMMENDATIONS CONCERNING DOCTORS, ETHICS, AND TORTURE

*(Standing Committee of European Doctors, 1989)*

Having taken into consideration the recommendations of the international meeting on Doctors, Ethics, and Torture held in Copenhagen on 23 August 1986, the Plenary Assembly of the Standing Committee of Doctors of the European Communities meeting in Madrid on 24-25 November 1989, deliberated the problems faced by doctors and the organized medical profession in countries where torture is or has been employed.

The Plenary Assembly of the Standing Committee of Doctors of the EC agreed:

- to urge all national medical associations which have not yet done so to ratify, publicise, and implement the Tokyo Declaration (Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment) adopted by the World Medical Association in 1975 as the definitive statement of the position of the medical profession on this topic;
- to urge the inclusion and integration in the medical educational curricula of information about the existence of this problem and instruction in the ethical responsibilities and regulations by which the doctor is bound and to which he may refer when objected to pressure to act contrary to the best ethical principles of the medical profession;
- to urge all national governments which have not yet done so to ratify and implement the United Nations declaration of 1982 and other relevant international declarations on this topic;
- to urge all scientific and professional medical bodies and the profession in all countries to incorporate the principles of the Tokyo Declaration into their statutes,

and all other relevant documents, including a principle stating that a doctor shall never participate – directly or indirectly and even by his own presence – in a process or accept a procedure of any nature assigned to violate the physical or mental integrity of a person or the human dignity;

- to urge the establishment of an international reporting system regarding ethical infractions within the profession in this respect and to publicise information about the existence of torture and to urge that similar educational measures be taken for all health professions and police and military personnel, and to encourage and support research against torture and for treatment of the victims of torture, and
- to urge that international support be given by the profession to colleagues who take action to resist the involvement of doctors in such procedures and to mount an international protest against any efforts to hinder the profession in attempts to uphold the highest ethical principles of physicians.

Available online at: [www.unav.es/cdb/cpme89a.html](http://www.unav.es/cdb/cpme89a.html)

## DECLARATION OF PRINCIPLE – TORTURE

*(World Confederation for Physical Therapy, 1995, 2007)*

The World Confederation for Physical Therapy (WCPT) believes that:

1. Physical therapists shall not countenance, condone or participate in the practice of torture or cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. Physical therapists shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. Physical therapists shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.
4. Physical therapist's fundamental role is alleviating distress of his or her fellow human beings, and no motive whether personal, collective or political shall prevail against this higher purpose.
5. The practising physical therapist should understand the general and specific neurological, musculoskeletal and psychological dysfunction which can be expected to appear as the effects of physical and psychological torture, as well as of appropriate functional assessment and treatment procedures for survivors of torture.
6. Education regarding the prevention and prohibition of torture as well as the assessment and treatment of torture victims should be included in the curriculum for entry level and continuing physical therapy education programmes.

The World Confederation for Physical Therapy will support and encourage the international community, its member organisations and fellow physical therapists to

support the physical therapist and physical therapist's family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

Approved at the 13th General Meeting of WCPT, Washington DC, June 1995, revised and re-approved 2007.

Available online at: <http://www.wcpt.org/policies/principles/guidetorture.php>

## PLAN OF ACTION AGAINST TORTURE

*(Amnesty International, 1996)*

We, the participants in the International Conference on Torture, comprising Amnesty International members, other human rights defenders and experts from around the world, **United** in our abhorrence of torture and cruel, inhuman or degrading treatment or punishment and outraged by the impunity enjoyed by its perpetrators,

**Deeply angered** by the persistence of torture and ill-treatment, despite the fact that 99 countries have ratified the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Convention against Torture") since the Convention was adopted in 1984,

**Alarmed** by the continuing complacency and even acceptance of torture among parts of civil society,

**Determined** to press the authorities of all countries to honour their obligation to prevent torture, as established in the Convention against Torture and other international human rights instruments and national laws, reaffirmed at the 1993 Vienna Conference on Human Rights and summarized in Amnesty International's 12-Point Program for the Prevention of Torture,

**Stressing** that the victims of torture can include not only political prisoners, but members of vulnerable groups such as ethnic and sexual minorities, refugees and asylum-seekers, immigrants, common criminal suspects and prisoners, the socially deprived and economically marginalized, and people caught up in armed conflicts,

**Committed** to combat all forms of torture, including rape and sexual abuse, and to maintain a gender perspective in the fight against torture,

**Recognizing** the achievements of the past decades in exposing the facts of torture and pressing for action at the local, national and international levels,

**Mindful** of the need for human rights defenders to continue their vital work against torture through investigation, action through the courts, campaigning, and providing support to the victims of torture and their families,

**Convinced** of the need to find new means of action for civil society to combat torture everywhere,

Adopt the following Plan of Action and commend it to the attention of non-governmental organizations and concerned individuals as a program of steps to be taken in the coming years.

## **PLAN OF ACTION**

### **I. ACTION AT NATIONAL LEVEL**

#### **Plans for abolition**

National non-governmental organizations (NGOs) in every country should draw up comprehensive plans for the abolition of torture. They should work for legal and institutional reform where needed, and for proper training of all those involved in the administration of justice. NGOs should maintain vigilance at all times so that any occurrence of torture is exposed and swiftly acted on. Public awareness, campaigning and human rights education should be integral to their work. They should urge governments to ratify UN and regional human rights treaties.

NGOs should give special support to vulnerable social groups, making them aware of what constitutes torture, and of their rights and how to defend them.

#### **Inspection visits**

NGOs should promote the right of relevant NGOs and independent national institutions to make unannounced and unrestricted visits to all places of detention, including those under military jurisdiction.

#### **Legislation**

NGOs in each country should work for the adoption of comprehensive legislation for the prohibition and prevention of torture. The legislation should establish that torture is a specific criminal offence, defined in a way that is not narrower than the definition in the Convention against Torture. Torture and ill-treatment should be punishable by penalties which take into account their seriousness. The legislation should provide for other elements needed for the prevention of torture, including the holding of prompt, impartial and effective investigations into complaints and reports of torture; safeguards on arrest and during detention, including prompt and regular access to lawyers, doctors and relatives; bringing those responsible for torture to justice; and fair and adequate redress from the state, including appropriate medical care, financial compensation and rehabilitation for victims of torture and their dependants.

#### **Public opinion**

In engaging the public in the fight against torture, NGOs should emphasize that torture and ill-treatment violate the integrity and dignity of the human person, that they violate all accepted norms of civilized behaviour, that they are universally prohibited, are morally abhorrent and totally unacceptable in any form. NGOs should also stress that torture is a fundamentally flawed method of obtaining reliable evidence to combat crime. They should be familiar with the arguments which may be advanced as justifications for torture and should be prepared to confront them.

The news and entertainment media have an important role to play in the effort to abolish torture. They should refrain from portraying torture in a way that makes it seem acceptable.

**Police**

Respect for human rights is inherent in professional policing. Human rights education should be integrated into training programs on police ethics and professional conduct. Training programs should emphasize the ability of a professional police force to investigate crime and maintain law and order without resorting to torture.

An international code of practice for the professional conduct of interrogation should be developed, recognizing that no police or other law enforcement official may inflict, instigate or tolerate torture or other cruel, inhuman or degrading treatment.

**Impunity**

NGOs should explore ways of collecting information on those responsible for torture with a view to ensuring that governments bring them to justice. NGOs should campaign against amnesties granted before the truth is revealed and the perpetrators tried and sentenced.

NGOs should support torture victims in presenting their cases before official investigatory bodies and press for the evidence to be followed up.

**Armed opposition groups**

NGOs should campaign for armed opposition groups to commit themselves to and implement the prohibition of torture under international humanitarian law.

**Torture equipment and training**

NGOs should work together to ensure national and international monitoring and control of the provision of equipment, training, funding and other assistance for military, security or police use in order to ensure that this does not facilitate torture by governments or armed opposition groups.

**Rape and sexual abuse**

NGOs should strongly oppose all forms of sexual abuse by state agents, reaffirming in particular that rape clearly constitutes torture. They should pay special attention to the impact of cultural attitudes in aggravating the suffering of victims and their families.

**Asylum**

NGOs should campaign for governments not to return any person forcibly to a country where he or she risks being tortured.

**II. ACTION AT INTERNATIONAL LEVEL****Field Presence**

NGOs should work for the increased use of on-site international monitoring and investigation. Where such field presence can operate effectively and personnel are properly trained, it is a direct and potent way of protecting people from torture. All

UN and independent agencies with a field presence, whether involved in aid, development, economic or refugee projects, should be pressed to ensure that their presence contributes to the prevention of torture.

### **Global inspection system**

NGOs should work together for the adoption of the strongest possible Optional Protocol to the Convention against Torture providing for a global system of inspection visits to places of detention as a safeguard against torture. The system can and should be set up by the year 2000.

### **Resources**

NGOs should insist that more funds be allocated to the grossly under-funded human rights programs at the UN and regional intergovernmental organizations. Within the UN human rights program, more personnel should be allocated to bodies and mechanisms that combat torture, which are themselves under-resourced in comparison with other parts of the program. NGOs should campaign for increased donations to the UN Voluntary Fund for Victims of Torture.

### **International justice**

NGOs should press governments to pass effective laws and to take action so that alleged torturers from anywhere in the world who enter their country are investigated, arrested and prosecuted or extradited, as required by the Convention against Torture. NGOs should inform each other when alleged torturers enter a country so that the relevant government can be called on to act immediately.

NGOs should continue campaigning together for the establishment of a just, fair and effective permanent international criminal court by 1998.

### **Compensation**

NGOs should campaign for victims of torture in all countries to be able to obtain compensation through the courts from torturers irrespective of where the torture occurred and where the torturer lives.

### **Women**

NGOs should work to increase awareness of the standards and bodies relevant to the torture of women, including the UN Declaration on Violence against Women and the UN Special Rapporteur on Violence against Women. They should work to ensure that experts of intergovernmental bodies effectively and sensitively address the problem of the torture of women, and that an increasing number of these experts are women themselves.

### **National NGOs**

National NGOs should help strengthen the work of the UN Committee against Torture, the UN Special Rapporteur on torture and other intergovernmental bodies

and mechanisms by submitting information on torture in their countries, monitoring and publicizing the work of those bodies and encouraging victims and their families to submit individual cases. International and regional NGOs should assist national NGOs in this work, including by providing translations of important documents, practical training and funding.

Available online at: <http://www.amnesty.org/en/library/info/ACT40/002/1996>

## DECLARATION OF HAMBURG CONCERNING SUPPORT FOR MEDICAL DOCTORS

*(World Medical Association, 1997)*

### PREAMBLE

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.
2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolution on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Declaration of Hawaii.
3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

### RESOLUTION

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:
  - i. to encourage doctors to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;
  - ii. to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and,
  - iii. to extend its support and to encourage other international organisations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

- i. to protest internationally against any involvement of, or any pressure to involve, medical doctors in acts of or other forms of cruel, inhuman or degrading treatment or punishment;
- ii. to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;
- iii. to publicise information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and,
- iv. to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997.

Available online at: <http://www.wma.net/e/policy/c19.htm>

## TORTURE, DEATH PENALTY AND PARTICIPATION BY NURSES IN EXECUTIONS

*(International Council of Nurses, 1998, 2003, 2006)*<sup>1</sup>

### ICN POSITION

The International Council of Nurses strongly affirms that nurses should play no voluntary role in any deliberate infliction of physical or mental suffering and should not participate, either directly or indirectly, in the preparation for and the implementation of executions. To do otherwise is a clear violation of nursing's ethical code of practice.

The nurse's primary responsibility is to those people who require nursing care.

Nurses have a duty to provide the highest possible level of care to victims of cruel, degrading and inhumane treatment, and should speak up against and oppose any deliberate infliction of pain and suffering.

---

1. This text also appears in the Death Penalty section, to which it applies equally.

While ICN considers the death penalty to be unacceptable, clearly the nurse's responsibility to a prisoner sentenced to death continues until execution.

ICN urges its member national nurses' associations (NNAs) to lobby for abolition of the death penalty; to actively oppose torture and participation by nurses in executions; and to develop mechanisms to provide nurses with confidential advice and support in caring for prisoners sentenced to death or subjected to torture.

ICN pledges to take appropriate action and urges NNAs and individual nurses to do the same in support of nurses who become victims of torture, cruel treatment or even death for upholding the professional ethical conduct and for their work in defending human rights.

ICN believes that all levels of nursing education curricula should include: recognition of human rights issues and violations, such as torture and death penalty; awareness of the use of medical technology including lethal injections for executions; and recognition of the nurse's right to refuse to participate in executions.

## **BACKGROUND**

Violations of human rights are pervasive and scientific advances have brought about sophisticated forms of torture. ICN supports the United Nations Universal Declaration of Human Rights and advocates upholding the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Istanbul Protocol on Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[1]

The ICN Code of Ethics for Nurses states that the fundamental responsibility of the nurse is to promote health, prevent illness, to restore health and to alleviate suffering. However we recognise that nurses are sometimes called upon to perform physical examinations before prisoners' interrogation and torture, to attend torture sessions in order to provide care, and/or to treat the effects of torture.

Efforts to regulate and 'humanise' the death penalty or even to 'medicalise' it have led to contradictory legal and ethical problems.

## **REFERENCES**

[1] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) Submitted to the: United Nations High Commissioner for Human Rights 9 September 1999.

This statement replaces previous ICN Positions Nurses and Torture, adopted 1989 and Death penalty and participation by nurses in execution, adopted 1989.

Available online at: <http://www.icn.ch/pstorture.htm>

## PRINCIPLES ON THE EFFECTIVE DOCUMENTATION OF TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

(Istanbul Protocol, 1999)

The following Principles evolved in the drafting of the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment which was submitted to the United Nations by an *ad hoc* coalition of professional and human rights bodies and individuals in August 1999.

### **Principles for the Effective Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**

The following principles represent a consensus among individuals and organizations having expertise in the investigation of torture.

1. The purposes of effective investigation and documentation of torture and other cruel, inhuman, or degrading treatment (hereafter torture or other ill treatment) include the following:
  - a. clarification of the facts and establishment and acknowledgement of individual and state responsibility for victims and their families;
  - b. identification of measures needed to prevent recurrence;
  - c. facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible, and demonstrating the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.
2. States shall ensure that complaints and reports of torture shall be promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill treatment may have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by, impartial medical or other experts. The methods used to carry out such investigations shall meet the highest professional standards, and the findings shall be made public.
  - 3a. The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry<sup>1</sup>. Those persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those allegedly involved in torture to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue

---

1. Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.

summonses to witnesses, including any officials allegedly involved and to demand the production of evidence.

**3b.** Alleged victims of torture, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture shall be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families, as well as those conducting the investigation.

**4.** Alleged victims of torture or ill treatment and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

**5a.** In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.<sup>2</sup>

**5b.** A written report, made within a reasonable period of time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report shall be made public. It shall also describe in detail specific events that were found to have occurred and the evidence upon which such findings were based, and list the names of witnesses who testified with the exception of those whose identities have been withheld for their own protection. The State shall, within a reasonable period of time, either reply to the report of the investigation or indicate the steps to be taken in response.

**6a.** Medical experts involved in the investigation of torture should behave at all times in conformity with the highest ethical standards and in particular shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

**6b.** The medical expert should promptly prepare an accurate written report. The report should include at least the following:

- i. Circumstances of the interview: name of the subject and names and affiliations of those present at the examination; the exact time and date, location,

---

2. See footnote 1 above.

nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); and the circumstances of the subject at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination demeanor of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

**ii.** History: A detailed record of the subject's story as given during the interview, including alleged methods of torture or ill treatment, the times when torture or ill treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

**iii.** Physical and psychological examination: A record of all physical and psychological findings on clinical examination including, appropriate diagnostic tests and, where possible, colour photographs of all injuries;

**iv.** Opinion: An interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill treatment. A recommendation for any necessary medical and psychological treatment and/or further examination should also be given;

**v.** Authorship: The report should clearly identify those carrying out the examination and should be signed.

**6c.** The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. It should also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report should not be made available to any other person except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer.

Available online at: [http://www.unmikonline.org/regulations/unmikgazette02english/Eirs/Convention\\_against\\_Torture\\_\(Principles\\_of\\_Effective\\_Investigation\).pdf](http://www.unmikonline.org/regulations/unmikgazette02english/Eirs/Convention_against_Torture_(Principles_of_Effective_Investigation).pdf)

## RESOLUTION ON THE RESPONSIBILITY OF PHYSICIANS IN THE DOCUMENTATION AND DENUNCIATION OF ACTS OF TORTURE OR CRUEL OR INHUMAN OR DEGRADING TREATMENT

*(World Medical Association, 2003, 2007)*

The World Medical Association,

**1.** Considering the Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, the dignity and value of the human person,

**2.** Considering the Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind,

3. Considering Article 5 of that Declaration which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment,
4. Considering the American Convention on Human Rights, which was adopted by the Organization of American States on 22 November 1969 and entered into force on 18 July 1978, and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987,
5. Considering the Declaration of Tokyo, adopted by the World Medical Association in 1975, which reaffirms the prohibition of any form of medical involvement or presence of a physician during torture or inhuman or degrading treatment,
6. Considering the Declaration of Hawaii, adopted by the World Psychiatric Association in 1977,
7. Considering the Declaration of Kuwait, adopted by the International Conference of Islamic Medical Associations in 1981,
8. Considering the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "It is a gross contravention of medical ethics... for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment...",
9. Considering the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the United Nations General Assembly on December 1984 and entered into force on 26 June, 1987,
10. Considering the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989,
11. Considering the Resolution on Human Rights adopted by the World Medical Association in Rancho Mirage, in October 1990 during the 42nd General Assembly and amended by the 45th, 46th and 47th General Assemblies,
12. Considering the Declaration of Hamburg, adopted by the World Medical Association in November 1997 during the 49th General Assembly, calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions,
13. Considering the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000,
14. Considering the Convention on the Rights of the Child, which was adopted by the United Nations on 20 November 1989 and entered into force on 2 September 1990, and
15. Considering the World Medical Association Declaration of Malta on Hunger Strikers, adopted by the 43rd World Medical Assembly Malta, November 1991 and amended by the WMA General Assembly, Pilanesberg, South Africa, October, 2006,

### **Recognizing**

16. That careful and consistent documentation and denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity,
17. That physicians, by ascertaining the sequelae and treating the victims of torture, either early or late after the event, are privileged witnesses of this violation of human rights,
18. That the victims, because of the psychological sequelae from which they suffer or the pressures brought on them, are often unable to formulate by themselves complaints against those responsible for the ill-treatment they have undergone,
19. That the absence of documenting and denouncing acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims,
20. That nevertheless there is no consistent and explicit reference in the professional codes of medical ethics and legislative texts of the obligation upon physicians to document, report or denounce acts of torture or inhuman or degrading treatment of which they are aware,

### **Recommends that National Medical Associations**

1. Attempt to ensure that detainees or victims of torture or cruelty or mistreatment have access to immediate and independent health care. Attempt to ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.
2. Promote awareness of the Istanbul Protocol and its Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment. This should be done at country level using different methods of information dissemination; including trainings, publications and web documents.
3. Disseminate to physicians the Istanbul Protocol.
4. Promote training of physicians on the identification of different modes of torture, in recognizing physical and psychological symptoms following specific forms of torture and in using the documentation techniques foreseen in the Istanbul Protocol to create documentation that can be used as evidence in legal or administrative proceedings.
5. Promote awareness of the correlation between the examination findings, understanding torture methods and the patients' allegations of abuse;
6. Facilitate the production of high-quality medical reports on torture victims for submission to judicial and administrative bodies;
7. Attempt to ensure that physicians observe informed consent and avoid putting individuals in danger while assessing or documenting signs of torture and ill-treatment;
8. Attempt to ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.

9. Support the adoption in their country of ethical rules and legislative provisions:
  - 9.1 aimed at affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware; depending on the circumstances, the report or denunciation would be addressed to medical, legal, national or international authorities, to non-governmental organizations or to the International Criminal Court. Doctors should use their discretion in this matter, bearing in mind paragraph 68 of the Istanbul Protocol.
  - 9.2 establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.
  - 9.3 cautioning physicians to avoid putting individuals in danger by reporting on a named basis a victim who is deprived of freedom, subjected to constraint or threat or in a compromised psychological situation.
10. Place at their disposal all useful information on reporting procedures, particularly to the national authorities, nongovernmental organizations and the International Criminal Court.

Istanbul Protocol, paragraph 68: *“In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.”*

Available online at: <http://www.wma.net/e/policy/t1.htm>

## 12-POINT PROGRAMME FOR THE PREVENTION OF TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT BY AGENTS OF THE STATE

*(Amnesty International, 2005)*

Torture and other cruel, inhuman or degrading treatment or punishment (other ill-treatment) are violations of human rights, condemned by the international community as an offence to human dignity and prohibited in all circumstances under international law. Yet they happen daily and across the globe. Immediate steps are needed to confront these abuses wherever they occur and to eradicate them. Amnesty International calls on all governments to implement the following 12-point programme and invites concerned individuals and organizations to ensure that they do so. Amnesty International believes that the implementation of these measures is a positive indication of a government's commitment to end torture and other ill-treatment and to work for their eradication worldwide.

### **1. Condemn torture and other ill-treatment**

The highest authorities of every country should demonstrate their total opposition to torture and other ill-treatment. They should condemn these practices unreservedly whenever they occur. They should make clear to all members of the police, military and other security forces that torture and other ill-treatment will never be tolerated.

### **2. Ensure access to prisoners**

Torture and other ill-treatment often take place while prisoners are held incommunicado – unable to contact people outside who could help them or find out what is happening to them. The practice of incommunicado detention should be ended. Governments should ensure that all prisoners are brought before an independent judicial authority without delay after being taken into custody. Prisoners should have access to relatives, lawyers and doctors without delay and regularly thereafter.

### **3. No secret detention**

In some countries torture and other ill-treatment take place in secret locations, often after the victims are made to “disappear”. Governments should ensure that prisoners are held only in officially recognized places of detention and that accurate information about their arrest and whereabouts is made available immediately to relatives, lawyers, the courts, and others with a legitimate interest, such as the International Committee of the Red Cross (ICRC). Effective judicial remedies should be available at all times to enable relatives and lawyers to find out immediately where a prisoner is held and under what authority, and to ensure the prisoner's safety.

### **4. Provide safeguards during detention and interrogation**

All prisoners should be immediately informed of their rights. These include the right to lodge complaints about their treatment and to have a judge rule without

delay on the lawfulness of their detention. Judges should investigate any evidence of torture or other ill-treatment and order release if the detention is unlawful. A lawyer should be present during interrogations. Governments should ensure that conditions of detention conform to international standards for the treatment of prisoners and take into account the needs of members of particularly vulnerable groups. The authorities responsible for detention should be separate from those in charge of interrogation. There should be regular, independent, unannounced and unrestricted visits of inspection to all places of detention.

### **5. Prohibit torture and other ill-treatment in law**

Governments should adopt laws for the prohibition and prevention of torture and other ill-treatment incorporating the main elements of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture) and other relevant international standards. All judicial and administrative corporal punishments should be abolished. The prohibition of torture and other ill-treatment and the essential safeguards for their prevention must not be suspended under any circumstances, including states of war or other public emergency.

### **6. Investigate**

All complaints and reports of torture or other ill-treatment should be promptly, impartially and effectively investigated by a body independent of the alleged perpetrators. The scope, methods and findings of such investigations should be made public. Officials suspected of committing torture or other ill-treatment should be suspended from active duty during the investigation. Complainants, witnesses and others at risk should be protected from intimidation and reprisals.

### **7. Prosecute**

Those responsible for torture or other ill-treatment should be brought to justice. This principle applies wherever those suspected of these crimes happen to be, whatever their nationality or position, regardless of where the crime was committed and the nationality of the victims, and no matter how much time has elapsed since the commission of the crime. Governments should exercise universal jurisdiction over those suspected of these crimes, extradite them, or surrender them to an international criminal court, and cooperate in such criminal proceedings. Trials should be fair. An order from a superior officer should never be accepted as a justification for torture or ill-treatment.

### **8. No use of statements extracted under torture or other ill-treatment**

Governments should ensure that statements and other evidence obtained through torture or other ill-treatment may not be invoked in any proceedings, except against a person accused of torture or other ill-treatment.

**9. Provide effective training**

It should be made clear during the training of all officials involved in the custody, interrogation or medical care of prisoners that torture and other ill-treatment are criminal acts. Officials should be instructed that they have the right and duty to refuse to obey any order to torture or carry out other ill-treatment.

**10. Provide reparation**

Victims of torture or other ill-treatment and their dependants should be entitled to obtain prompt reparation from the state including restitution, fair and adequate financial compensation and appropriate medical care and rehabilitation.

**11. Ratify international treaties**

All governments should ratify without reservations international treaties containing safeguards against torture and other ill-treatment, including the International Covenant on Civil and Political Rights and its first Optional Protocol; and the UN Convention against Torture, with declarations providing for individual and inter-state complaints, and its Optional Protocol. Governments should comply with the recommendations of international bodies and experts on the prevention of torture and other ill-treatment.

**12. Exercise international responsibility**

Governments should use all available channels to intercede with the governments of countries where torture or other ill-treatment are reported. They should ensure that transfers of training and equipment for military, security or police use do not facilitate torture or other ill-treatment. Governments must not forcibly return or transfer a person to a country where he or she would be at risk of torture or other ill-treatment.

This 12-point programme sets out measures to prevent the torture and other ill-treatment of people who are in governmental custody or otherwise in the hands of agents of the state. It was first adopted by Amnesty International in 1984, revised in October 2000 and again in April 2005. Amnesty International holds governments to their international obligations to prevent and punish torture and other ill-treatment, whether committed by agents of the state or by other individuals. Amnesty International also opposes torture and other ill-treatment by armed political groups.

Available online at: [www.amnesty.org/en/library/asset/ACT40/001/2005/en/dom-ACT400012005en.html](http://www.amnesty.org/en/library/asset/ACT40/001/2005/en/dom-ACT400012005en.html)

## 22/TRANSPLANTATION

- Statement of the Transplantation Society Ethics Committee (Transplantation Society, undated)
- Human Organ and Tissue Transplantation (World Health Assembly, 2004)
- Statement on Human Tissue for Transplantation (World Medical Association, 2007)
- Declaration of Istanbul on Organ Trafficking and Transplant Tourism (International Summit on Transplant Tourism and Organ Trafficking, 2008)
- Guiding Principles on Human Cell, Tissue and Organ Transplantation (World Health Organization, 2009)

### STATEMENT OF THE TRANSPLANTATION SOCIETY ETHICS COMMITTEE

*(Transplantation Society, undated)*

#### MEMBERSHIP STATEMENT

The Transplantation Society is the leading international society of physicians, surgeons and scientists involved in the transplantation of organs and tissues. The membership should be active in promoting organ donation from deceased as well as from live donors. The Society is proactive in the development of international transplant policy, the monitoring of transplantation activities and in supervision of the adherence to proper principles of practice.

It is a fundamental principle for The Transplantation Society that donors of organs and tissues are not exploited and that consent for donation must be obtained without coercion. The Transplantation Society opposes the buying and selling of organs. Two models of authorization for organ donation from the deceased donor, explicit consent or registered objection, are practiced. In countries using the system of registered objection, extensive efforts should be taken in order to ascertain that the public knows its right to object. Members of The Transplantation Society must not be involved in obtaining or transplanting organs from executed prisoners or other donors where there is a risk that an autonomous consent for donation is lacking.

The applicant for membership in The Transplantation Society should review the Policy and Ethics Statement at the following TTS website:

<http://www.transplantation-soc.org/policy.php>

Applicants for membership in The Transplantation Society should also be aware of the following positions of the Society:

1. All countries with donation and organ and tissue transplantation activities should have relevant legislation ensuring transparency, safety and effective monitoring of the procedures.
2. All countries should enact legislation prohibiting exploitation of donors by commercial trafficking in organs and tissues.
3. All countries should have a system for approval and certification of transplant centres and physicians by relevant government and/or medical professional authorities.
4. All countries should have methods for registration and tracking of all organ and tissue donors.
5. All countries should have systems to ensure that the allocation of organs is transparent and governed by medical criteria.
6. All countries obtaining organs from deceased individuals should legally define death and the criteria to diagnose death. The determination of death should be independent of a direct interest in a subsequent organ transplant procedure. No organs or tissues should be removed unless the individual is declared dead.
7. In the case of live donation, all countries should be guided by relevant legislation and monitoring to ensure that:
  - a. only individuals with the cognitive capacity to understand the risks and benefits of being a live donor are accepted as donors;
  - b. potential donors receive the relevant and sufficient information about the procedure to make an autonomous decision;
  - c. the decision to donate is voluntary, free of exploitation and coercion;
  - d. all donors receive a complete medical and psychosocial evaluation and are cared for throughout the postoperative recovery period;
  - e. donor's access to long-term follow-up is promoted. Scientific studies and clinical activities should be performed in keeping with the ethical principles delineated in the following policy documents:

For Live Kidney Donation – The Consensus Statement of the Amsterdam Forum (Transplantation 79(6): S53-S66, 2005)

For Live Donation of Extrarenal Organs – The consensus Statement of the Vancouver Forum (Transplantation 81(4): 1373-1385, 2006)

For Studies of Xenotransplantation – The International Xenotransplantation Association Ethics Committee Position Paper on “The Ethics of Xenotransplantation” (Xenotransplantation 10:194-203, 2003)

For research involving human subjects – The Helsinki Declaration of The World Medical Association.

I Hereby Accept to Practice According to the Policy and Ethics Statement of The Transplantation Society and the Positions of the Transplantation Society Stated Above.

SIGNATURE

DATE

PRINT NAME

Available online at: [http://www.transplantation-soc.org/downloads/TTS\\_Ethics\\_Policy.pdf](http://www.transplantation-soc.org/downloads/TTS_Ethics_Policy.pdf)

## HUMAN ORGAN AND TISSUE TRANSPLANTATION

(World Health Assembly, 2004)

The Fifty-seventh World Health Assembly,

**Recalling** resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation;

**Having** considered the report on human organ and tissue transplantation;<sup>1</sup>

**Noting** the global increase in allogeneic transplantation of cells, tissues and organs;

**Concerned** by the growing insufficiency of available human material for transplantation to meet patient needs;

**Aware** of ethical and safety risks arising in the transplantation of allogeneic cells, tissues and organs, and the need for special attention to the risks of organ trafficking;

**Recognizing** that living xenogeneic cells, tissues or organs, and human bodily fluids, cells, tissues or organs that have had *ex vivo* contact with these living xenogeneic materials, have the potential to be used in human beings when suitable human material is not available;

**Mindful** of the risk associated with xenogeneic transplantation of the transmission of known or as yet unrecognized xenogeneic infectious agents from animals to human beings and from recipients of xenogeneic transplants to their contacts and the public at large;

**Recognizing** that transplantation encompasses not only medical but also legal and ethical aspects, and involves economic and psychological issues,

I

### Allogeneic transplantation

1. *URGES Member States:*

a. to implement effective national oversight of procurement, processing and transplantation of human cells, tissues and organs, including ensuring accountability for human material for transplantation and its traceability;

b. to cooperate in the formulation of recommendations and guidelines to harmonize global practices in the procurement, processing and transplantation of human cells, tissues and organs, including development of minimum criteria for suitability of donors of tissues and cells;

---

1. [World Health Assembly] Document A57/17.

- c. to consider setting up ethics commissions to ensure the ethics of cell, tissue and organ transplantation;
  - d. to extend the use of living kidney donations when possible, in addition to donations from deceased donors;
  - e. to take measures to protect the poorest and vulnerable groups from “transplant tourism” and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs;
2. *REQUESTS the Director-General:*
- a. to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation, in order to update the Guiding Principles on Human Organ Transplantation;<sup>2</sup>
  - b. to promote international cooperation so as to increase the access of citizens to these therapeutic procedures;
  - c. to provide, in response to requests from Member States, technical support for developing suitable transplantation of cells, tissues or organs, in particular by facilitating international cooperation;
  - d. to provide support for Member States in their endeavours to prevent organ trafficking, including drawing up guidelines to protect the poorest and most vulnerable groups from being victims of organ trafficking;

## II

### **Xenogeneic transplantation**

1. *URGES Member States:*
- a. to allow xenogeneic transplantation only when effective national regulatory control and surveillance mechanisms overseen by national health authorities are in place;
  - b. to cooperate in the formulation of recommendations and guidelines to harmonize global practices, including protective measures in accordance with internationally accepted scientific standards to prevent the risk of potential secondary transmission of any xenogeneic infectious agent that could have infected recipients of xenogeneic transplants or contacts of recipients, especially across national borders;
  - c. to support international collaboration and coordination for the prevention and surveillance of infections resulting from xenogeneic transplantation;
2. *REQUESTS the Director-General:*
- a. to facilitate communication and international collaboration among health authorities in Member States on issues relating to xenogeneic transplantation;

---

2. Document WHA44/1991/REC/1, Annex 6.

- b. to collect data globally for the evaluation of practices in xenogeneic transplantation;
- c. to inform proactively Member States of infectious events of xenogeneic origin arising from xenogeneic transplantation;
- d. to provide, in response to requests from Member States, technical support in strengthening capacity and expertise in the field of xenogeneic transplantation, including policymaking and oversight by national regulatory authorities;
- e. to report at an appropriate time to the Health Assembly, through the Executive Board, on implementation of this resolution.

World Health Assembly resolution WHA57.18; From Eighth plenary meeting, 22 May 2004 – Committee A, third report.

Available online at:

[http://www.who.int/gb/ebwha/pdf\\_files/WHA57/A57\\_R18-en.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R18-en.pdf)

## STATEMENT ON HUMAN TISSUE FOR TRANSPLANTATION

*(World Medical Association, 2007)*

### INTRODUCTION

The use of human cells and tissue for therapeutic purposes in medicine covers a broad spectrum. A differentiated examination is necessary in order to do justice to the different requirements of the various sectors of tissue medicine.

The use of so-called “tissue transplants”, such as corneas, bone, blood vessels and cardiac valves, is an established treatment method in medicine. Tissues are removed, conserved, stored and then implanted in patients after varying periods of time. In principle, they should therefore be treated in the same way as organs that are used for transplantation (cf. WMA Statement on Human Organ and Tissue Donation and Transplantation, Edinburgh 2000).

In contrast, so-called “advanced therapies”, such as tissue engineering and other techniques of regenerative medicine, involve the use of human tissue as starting material for manufacturing a processed end product. Even though established therapeutic options already exist, it can be expected that the therapeutic importance of these methods may continue to increase, and that there may be many developments in this field in the future. In view of the further processing of the tissue involved, the frequently industrial nature of the manufacturing organizations and the possibility of tissue being pooled, different regulations are necessary for this sector of tissue medicine than for tissue transplantation.

The WMA limits this Statement to tissue in the sense of tissue transplants, and gives the following Recommendations for this sector of tissue medicine:

1. Physicians are fundamentally obliged to treat patients according to the best of their knowledge and expertise. However, this obligation must not be taken to the

point where, for example, the human tissue necessary for therapy is procured in an unethical or illegal manner. Tissue must always be procured with due consideration for human rights and the principles of medical ethics.

- 2.** To secure the provision of tissue for transplantation, physicians should inform potential donors and/or their family members about the possibility of tissue donation. In the event of combined organ and tissue donation, information should be provided, and consent obtained, in one step.
- 3.** The voluntariness of tissue donation must be ensured. The informed and non-coerced consent of the donor or his/her family members is required for any use of human tissue for transplantation. Free and informed decision-making is a process requiring the exchange and understanding of information and the absence of coercion. Because prisoners and other individuals in custody are not in a position to give consent freely and can be subject to coercion, their tissues must not be used for transplantation except for members of their immediate family.
- 4.** Financial incentives such as direct payments for donating tissue for transplantation are to be rejected – in the same way that they are in connection with organ transplants. All other steps, such as the procurement, testing, processing, conservation, storage and allocation of tissue transplants, should likewise not be commercialised.
- 5.** If both organs and tissue can be removed from a potential donor for transplantation, organ donation must be given priority over tissue donation.
- 6.** Posthumous donation of tissue to a specific recipient (directed donation beyond the immediate family) is to be avoided. Living directed donation requires both:
  - a.** proof of direct personal ties between donor and recipient (e.g. blood relations, spouses), and
  - b.** exclusion of potentially coercive material interests.
- 7.** For posthumous tissue donation, the WMA calls for the determination of death to be conducted in accordance with its Declaration of Sydney on the Determination of Death.
- 8.** The risk of diseases (e.g. infections, malignant tumors) being transmitted by transplanted tissue must be minimized through appropriate testing that does not merely comply with sufficient standards, but additionally reflects the respective, nationally implemented state of medical science and technology.
- 9.** In the case of a delayed diagnosis for infectious disease or malignancy of the donor, an alert should immediately be reported to all tissue recipients in order to institute the appropriate precautionary steps.
- 10.** Contamination must be avoided when removing, storing, processing and transplanting tissue.
- 11.** Unethical allocation formulas for tissue transplants are to be rejected. Allocation should be based on the medical indication, urgency and prospects of success.
- 12.** Experimental and clinical studies, as well as open discussions on ethical and moral principles in society, are important for establishing new therapeutic methods.

All experimental and clinical studies are to be conducted in accordance with the WMA Declaration of Helsinki. Scientists and physicians should continuously inform the public about developments in tissue medicine and its therapeutic options.

**13.** International exchange of tissue for transplantation should be properly regulated according to agreed upon standards.

**14.** Information on tissue donors should be stored and maintained by national transplant organizations and should be provided only if the living donor or family of the deceased donor provides free and informed consent.

Available online at: <http://www.wma.net/e/policy/t4.htm>

## DECLARATION OF ISTANBUL ON ORGAN TRAFFICKING AND TRANSPLANT TOURISM

*(International Summit on Transplant Tourism and Organ Trafficking, 2008)*

### PREAMBLE

Organ transplantation, one of the medical miracles of the twentieth century, has prolonged and improved the lives of hundreds of thousands of patients worldwide. The many great scientific and clinical advances of dedicated health professionals, as well as countless acts of generosity by organ donors and their families, have made transplantation not only a life-saving therapy but a shining symbol of human solidarity. Yet these accomplishments have been tarnished by numerous reports of trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people. In 2004, the World Health Organization, called on member states “to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs”. [1]

To address the urgent and growing problems of organ sales, transplant tourism and trafficking in organ donors in the context of the global shortage of organs, a Summit Meeting of more than 150 representatives of scientific and medical bodies from around the world, government officials, social scientists, and ethicists, was held in Istanbul from April 30 to May 2, 2008. Preparatory work for the meeting was undertaken by a Steering Committee convened by The Transplantation Society (TTS) and the International Society of Nephrology (ISN) in Dubai in December 2007. That committee’s draft declaration was widely circulated and then revised in light of the comments received. At the Summit, the revised draft was reviewed by working groups and finalized in plenary deliberations.

This Declaration represents the consensus of the Summit participants. All countries need a legal and professional framework to govern organ donation and transplantation activities, as well as a transparent regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices.

Unethical practices are, in part, an undesirable consequence of the global shortage of organs for transplantation. Thus, each country should strive both to ensure that programs to prevent organ failure are implemented and to provide organs to meet the transplant needs of its residents from donors within its own population or through regional cooperation. The therapeutic potential of deceased organ donation should be maximized not only for kidneys but also for other organs, appropriate to the transplantation needs of each country. Efforts to initiate or enhance deceased donor transplantation are essential to minimize the burden on living donors. Educational programs are useful in addressing the barriers, misconceptions and mistrust that currently impede the development of sufficient deceased donor transplantation; successful transplant programs also depend on the existence of the relevant health system infrastructure.

Access to healthcare is a human right but often not a reality. The provision of care for living donors before, during and after surgery as described in the reports of the international forums organized by TTS in Amsterdam and Vancouver [2],[3],[4] is no less essential than taking care of the transplant recipient. A positive outcome for a recipient can never justify harm to a live donor; on the contrary, for a transplant with a live donor to be regarded as a success means that both the recipient and the donor have done well.

This Declaration builds on the principles of the Universal Declaration of Human Rights.[5] The broad representation at the Istanbul Summit reflects the importance of international collaboration and global consensus to improve donation and transplantation practices. The Declaration will be submitted to relevant professional organizations and to the health authorities of all countries for consideration. The legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism but rather a celebration of the gift of health by one individual to another.

## DEFINITIONS

**Organ trafficking** is the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.[6]

**Transplant commercialism** is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

**Travel for transplantation** is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes transplant tourism if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

## PRINCIPLES

1. National governments, working in collaboration with international and non-governmental organizations, should develop and implement comprehensive programs for the screening, prevention and treatment of organ failure, which include:
  - a. The advancement of clinical and basic science research; Effective programs, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programs for renal patients,
  - b. to minimize morbidity and mortality, alongside transplant programs for such diseases;
  - c. Organ transplantation as the preferred treatment for organ failure for medically suitable recipients.
2. Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.
  - a. Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles;
  - b. The practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety;
  - c. Oversight requires a national or regional registry to record deceased and living donor transplants;
  - d. Key components of effective programs include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.
3. Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.
  - a. Financial considerations or material gain of any party must not influence the application of relevant allocation rules.
4. The primary objective of transplant policies and programs should be optimal short- and long-term medical care to promote the health of both donors and recipients.
  - a. Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.
5. Jurisdictions, countries and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.
  - a. Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles;

- b. Treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.
- 6. Organ trafficking and transplant tourism violate the principles of equity, justice and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.
  - a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.
  - b. Such prohibitions should also include penalties for acts such as medically screening donors or organs, or transplanting organs that aid, encourage, or use the products of organ trafficking or transplant tourism.
  - c. Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism and transplant commercialism.

## PROPOSALS

Consistent with these principles, participants in the Istanbul Summit suggest the following strategies to increase the donor pool and to prevent organ trafficking, transplant commercialism and transplant tourism and to encourage legitimate, life-saving transplantation programs:

### To respond to the need to increase deceased donation:

1. Governments, in collaboration with health care institutions, professionals, and non-governmental organizations should take appropriate actions to increase deceased organ donation. Measures should be taken to remove obstacles and disincentives to deceased organ donation.
2. In countries without established deceased organ donation or transplantation, national legislation should be enacted that would initiate deceased organ donation and create transplantation infrastructure, so as to fulfill each country's deceased donor potential.
3. In all countries where deceased organ donation has been initiated, the therapeutic potential of deceased organ donation and transplantation should be maximized.
4. Countries with well established deceased donor transplant programs are encouraged to share information, expertise and technology with countries seeking to improve their organ donation efforts.

**To ensure the protection and safety of living donors and appropriate recognition for their heroic act while combating transplant tourism, organ trafficking and transplant commercialism:**

1. The act of donation should be regarded as heroic and honored as such by representatives of the government and civil society organizations.
2. The determination of the medical and psychosocial suitability of the living donor should be guided by the recommendations of the Amsterdam and Vancouver Forums. [2],[3],[4]
  - a. Mechanisms for informed consent should incorporate provisions for evaluating the donor's understanding, including assessment of the psychological impact of the process;
  - b. All donors should undergo psychosocial evaluation by mental health professionals during screening.
3. The care of organ donors, including those who have been victims of organ trafficking, transplant commercialism, and transplant tourism, is a critical responsibility of all jurisdictions that sanctioned organ transplants utilizing such practices.
4. Systems and structures should ensure standardization, transparency and accountability of support for donation.
  - a. Mechanisms for transparency of process and follow-up should be established;
  - b. Informed consent should be obtained both for donation and for follow-up processes.
5. Provision of care includes medical and psychosocial care at the time of donation and for any short- and long-term consequences related to organ donation.
  - a. In jurisdictions and countries that lack universal health insurance, the provision of disability, life, and health insurance related to the donation event is a necessary requirement in providing care for the donor;
  - b. In those jurisdictions that have universal health insurance, governmental services should ensure donors have access to appropriate medical care related to the donation event;
  - c. Health and/or life insurance coverage and employment opportunities of persons who donate organs should not be compromised;
  - d. All donors should be offered psychosocial services as a standard component of follow-up;
  - e. In the event of organ failure in the donor, the donor should receive:
    - i. Supportive medical care, including dialysis for those with renal failure, and
    - ii. Priority for access to transplantation, integrated into existing allocation rules as they apply to either living or deceased organ transplantation.
6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ, but is rather part of the legitimate costs of treating the recipient.

- a. Such cost-reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);
  - b. Relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;
  - c. Reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);
  - d. Reimbursement of the donor's lost income and out-of-pocket expenses should be administered by the agency handling the transplant rather than paid directly from the recipient to the donor.
7. Legitimate expenses that may be reimbursed when documented include:
- a. The cost of any medical and psychological evaluations of potential living donors who are excluded from donation (e.g. because of medical or immunologic issues discovered during the evaluation process);
  - b. Costs incurred in arranging and effecting the pre-, peri- and post-operative phases of the donation process (e.g. long-distance telephone calls, travel, accommodation and subsistence expenses);
  - c. Medical expenses incurred for post-discharge care of the donor;
  - d. Lost income in relation to donation (consistent with national norms).

## REFERENCES

- [1] World Health Assembly Resolution 57.18, Human organ and tissue transplantation. [cited on 2008 Sept 16]. Available from: [http://www.who.int/gb/ebwha/pdf\\_files/WHA57/A57\\_R18-en.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R18-en.pdf).
- [2] The Ethics Committee of the Transplantation Society. The consensus statement of the Amsterdam forum on the care of the live kidney donor. *Transplantation* 2004;78:491-2.
- [3] Barr ML, Belghiti J, Villamil FG, Pomfret EA, Sutherland DS, Gruessner RW, et al. A report of the Vancouver forum on the care of the life organ donor: Lung, liver, pancreas, and intestine data and medical guidelines. *Transplantation* 2006;81:1373-85.
- [4] Pruett TL, Tibell A, Alabdulkareem A, Bhandari M, Cronon DC, Dew MA, et al. The ethics statement of the Vancouver forum on the live lung, liver, pancreas, and intestine donor. *Transplantation* 2006;81:1386-7.
- [5] Universal Declaration of Human Rights. Adopted by the UN General Assembly. [cited on 2008 Sept 16]. Available from: <http://www.un.org/Overview/rights.html>.
- [6] Based on Article 3a of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime. [cited on 2008 Sept 16].

Available online at:

<http://www.indianjnephrol.org/text.asp?2008/18/3/135/43686>

## GUIDING PRINCIPLES ON HUMAN CELL, TISSUE AND ORGAN TRANSPLANTATION<sup>1</sup>

(World Health Organization, 2009)

### PREAMBLE

1. As the Director-General's report to the Executive Board at its Seventy-ninth session pointed out,<sup>2</sup> human organ transplantation began with a series of experimental studies at the beginning of the twentieth century. The report drew attention to some of the major clinical and scientific advances in the field since Alexis Carrel was awarded the Nobel Prize in 1912 for his pioneering work. Surgical transplantation of human organs from deceased, as well as living, donors to sick and dying patients began after the Second World War. Over the past 50 years, the transplantation of human organs, tissues and cells has become a worldwide practice which has extended, and greatly enhanced the quality of, hundreds of thousands of lives. Continuous improvements in medical technology, particularly in relation to organ and tissue rejection, have led to an increase in the demand for organs and tissues, which has always exceeded supply despite substantial expansion in deceased organ donation as well as greater reliance on donation from living persons in recent years.

2. The shortage of available organs has not only prompted many countries to develop procedures and systems to increase supply but has also stimulated commercial traffic in human organs, particularly from living donors who are unrelated to recipients. The evidence of such commerce, along with the related traffic in human beings, has become clearer in recent decades. Moreover, the growing ease of international communication and travel has led many patients to travel abroad to medical centres that advertise their ability to perform transplants and to supply donor organs for a single, inclusive charge.

3. Resolutions WHA40.13 and WHA42.5 first expressed the Health Assembly's concern over commercial trade in organs and the need for global standards for transplantation. Based on a process of consultation undertaken by the Secretariat, the Health Assembly then endorsed the WHO Guiding Principles on Human Organ Transplantation in resolution WHA44.25. Over the past 17 years the Guiding Principles have greatly influenced professional codes and practices as well as legislation around the world. In the light of changes in practices and attitudes regarding organ and tissue transplantation, the Fifty-seventh World Health Assembly in resolution WHA.57.18 requested the Director-General, *inter alia*, "to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues,

---

1. The revised official WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation were contained in EB123/5 noted by the Executive Board at its 123rd session on 26 May 2008, with a requested modification.

2. Document EB79/8

including living donation, in order to update the Guiding Principles on Human Organ Transplantation”.

**4.** The following Guiding Principles are intended to provide an orderly, ethical and acceptable framework for the acquisition and transplantation of human cells, tissues and organs for therapeutic purposes. Each jurisdiction will determine the means of implementing the Guiding Principles. They preserve the essential points of the 1991 version while incorporating new provisions in response to current trends in transplantation, particularly organ transplants from living donors and the increasing use of human cells and tissues. The Guiding Principles do not apply to transplantation of gametes, ovarian or testicular tissue, or embryos for reproductive purposes, or to blood or blood constituents collected for transfusion purposes.

Cells, tissues and organs may be removed from deceased and living persons for the purpose of transplantation, only in accordance with the following Guiding Principles.

### **Guiding Principle 1**

Cells, tissues and organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

- a.** any consent required by law is obtained, and
- b.** there is no reason to believe that the deceased person objected to such removal.

#### *Commentary on Guiding Principle 1*

Consent is the ethical cornerstone of all medical interventions. National authorities are responsible for defining the process of obtaining and recording consent for cell, tissue and organ donation in the light of international ethical standards, the manner in which organ procurement is organized in their country, and the practical role of consent as a safeguard against abuses and safety breaches.

Whether consent to procure organs and tissues from deceased persons is “explicit” or “presumed” depends upon each country’s social, medical and cultural traditions, including the manner in which families are involved in decision-making about health care generally. Under both systems any valid indication of deceased persons’ opposition to posthumous removal of their cells, tissues or organs will prevent such removal.

Under a regime of explicit consent – sometimes referred to as “opting in” – cells, tissues or organs may be removed from a deceased person if the person had expressly consented to such removal during his or her lifetime; depending upon domestic law, such consent may be made orally or recorded on a donor card, driver’s license or identity card or in the medical record or a donor registry. When the deceased has neither consented nor clearly expressed opposition to organ removal, permission should be obtained from a legally specified surrogate, usually a family member.

The alternative, presumed consent system – termed “opting (or contracting) out” – permits material to be removed from the body of a deceased person for

transplantation and, in some countries, for anatomical study or research, unless the person had expressed his or her opposition before death by filing an objection with an identified office, or an informed party reports that the deceased definitely voiced an objection to donation. Given the ethical importance of consent, such a system should ensure that people are fully informed about the policy and are provided with an easy means to opt out.

Although expressed consent is not required in an opting-out system before removal of the cells, tissues or organs of a deceased person who had not objected while still alive, procurement programmes may be reluctant to proceed if the relatives personally oppose the donation; likewise, in opting-in systems, programmes typically seek permission from the family even when the deceased gave pre-mortem consent. Programmes are more able to rely on the deceased's explicit or presumed consent, without seeking further permission from family members, when the public's understanding and acceptance of the process of donating cells, tissues and organs is deep-seated and unambiguous. Even when permission is not sought from relatives, donor programmes need to review the deceased's medical and behavioural history with family members who knew him or her well, since accurate information about donors helps to increase the safety of transplantation.

For tissue donation, which entails slightly less challenging time constraints, it is recommended always to seek the approval of the next of kin. An important point to be addressed is the manner in which the appearance of the deceased's body will be restored after the tissues are removed.

### **Guiding Principle 2**

Physicians determining that a potential donor has died should not be directly involved in cell, tissue or organ removal from the donor or subsequent transplantation procedures; nor should they be responsible for the care of any intended recipient of such cells, tissues and organs.

#### *Commentary on Guiding Principle 2*

This Principle is designed to avoid the conflict of interest that would arise were the physician or physicians determining the death of a potential donor to be responsible in addition for the care of other patients whose welfare depended on cells, tissues or organs transplanted from that donor.

National authorities will set out the legal standards for determining that death has occurred and specify how the criteria and process for determining death will be formulated and applied.

### **Guiding Principle 3**

Donation from deceased persons should be developed to its maximum therapeutic potential, but adult living persons may donate organs as permitted by domestic regulations. In general living donors should be genetically, legally or emotionally related to their recipients.

Live donations are acceptable when the donor's informed and voluntary consent is obtained, when professional care of donors is ensured and follow-up is well organized, and when selection criteria for donors are scrupulously applied and monitored. Live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion; they should be legally competent and capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion.

*Commentary on Guiding Principle 3*

The Principle emphasizes the importance both of taking the legal and logistical steps needed to develop deceased donor programmes where these do not exist and of making existing programmes as effective and efficient as possible.

While favouring the maximal development of transplant programmes that avoid the inherent risks to live donors, the Principle also sets forth basic conditions for live donation. A genetic relationship between donor and recipient may be therapeutically advantageous and can provide reassurance that the donor is motivated by genuine concern for the recipient, as can a legal relationship (such as that between spouses). Many altruistic donations also originate from emotionally related donors, though the strength of a claimed connection may be difficult to evaluate. Donations by unrelated donors have been a source of concern, though some such cases are unexceptionable, such as in hematopoietic stem cell transplantation (where a wide donor pool is therapeutically advisable) or when an exchange of kidneys is made because the donors are not immunologically well matched with the recipients to whom they are related.

With live donation, particularly by unrelated donors, psychosocial evaluation is needed to guard against coercion of the donor or the commercialism banned by Principle 5. The national health authority should ensure that the evaluation is carried out by an appropriately qualified, independent party. By assessing the donor's motivation and the donor's and recipient's expectations regarding outcomes, such evaluations may help identify – and avert – donations that are forced or are actually paid transactions.

The Principle underscores the necessity of genuine and well-informed choice, which requires full, objective, and locally relevant information and excludes vulnerable persons who are incapable of fulfilling the requirements for voluntary and knowledgeable consent. Voluntary consent also implies that adequate provisions exist for withdrawal of consent up until medical interventions on the recipient have reached the point where the recipient would be in acute danger if the transplant did not proceed. This should be communicated at the time of consent.

Finally, this Principle stresses the importance of protecting the health of living donors during the process of selection, donation, and necessary aftercare to ensure that the potential untoward consequences of the donation are unlikely to disadvantage the remainder of the donor's life. Care for the donor should match care for the recipient, and health authorities have the same responsibility for the welfare of both.

#### **Guiding Principle 4**

No cells, tissues or organs should be removed from the body of a living minor for the purpose of transplantation other than narrow exceptions allowed under national law. Specific measures should be in place to protect the minor and, wherever possible the minor's assent should be obtained before donation. What is applicable to minors also applies to any legally incompetent person.

##### *Commentary on Guiding Principle 4*

This Principle states a general prohibition on the removal of cells, tissues or organs from legal minors for transplantation. The major exceptions that may be authorized are familial donation of regenerative cells (when a therapeutically comparable adult donor is not available) and kidney transplants between identical twins (where avoiding immunosuppression represents a benefit to the recipient adequate to justify the exception, in the absence of a genetic disorder that could adversely affect the donor in the future).

While the permission of the parent(s) or the legal guardian for organ removal is usually sufficient, they may have a conflict of interest if they are responsible for the welfare of the intended recipient. In such cases, review and approval by an independent body, such as a court or other competent authority, should be required. In any event, a minor's objection to making a donation should prevail over the permission provided by any other party. The professional counselling provided to potential living donors in order to assess, and when needed, address any pressure in the decision to donate, is especially important for minor donors.

#### **Guiding Principle 5**

Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned.

The prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation.

##### *Commentary on Guiding Principle 5*

Payment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others.

Besides preventing trafficking in human materials, this Principle aims to affirm the special merit of donating human materials to save and enhance life. However, it allows for circumstances where it is customary to provide donors with tokens of gratitude that cannot be assigned a value in monetary terms. National law should

ensure that any gifts or rewards are not, in fact, disguised forms of payment for donated cells, tissues or organs. Incentives in the form of “rewards” with monetary value that can be transferred to third parties are not different from monetary payments.

While the worst abuses involve living organ donors, dangers also arise when payments for cells, tissues and organs are made to next of kin of deceased persons, to vendors or brokers, or to institutions (such as mortuaries) having charge of dead bodies. Financial returns to such parties should be forbidden.

This Principle permits compensation for the costs of making donations (including medical expenses and lost earnings for live donors), lest they operate as a disincentive to donation. The need to cover legitimate costs of procurement and of ensuring the safety, quality and efficacy of human cell and tissue products and organs for transplantation is also accepted.

Incentives that encompass essential items which donors would otherwise be unable to afford, such as medical care or health insurance coverage, raise concerns. Access to the highest attainable standard of health is a fundamental right, not something to be purchased in exchange for body parts. However, free periodic medical assessments related to the donation and insurance for death or complications that arise from the donation may legitimately be provided to living donors.

Health authorities should promote donation motivated by the need of the recipient and the benefit for the community. Any measures to encourage donation should respect the dignity of the donor and foster societal recognition of the altruistic nature of cell, tissue and organ donation. In any event, all practices to encourage the procurement of cells, tissues and organs for transplantation should be defined explicitly by health authorities in a transparent fashion.

National legal frameworks should address each country’s particular circumstances because the risks to donors and recipients vary. Each jurisdiction will determine the details and method of the prohibitions it will use, including sanctions which may encompass joint action with other countries in the region. The ban on paying for cells, tissues and organs should apply to all individuals, including transplant recipients who attempt to circumvent domestic regulations by travelling to locales where prohibitions on commercialization are not enforced.

### **Guiding Principle 6**

Promotion of altruistic donation of human cells, tissues or organs by means of advertisement or public appeal may be undertaken in accordance with domestic regulation.

Advertising the need for or availability of cells, tissues or organs, with a view to offering or seeking payment to individuals for their cells, tissues or organs, or, to the next of kin, where the individual is deceased, should be prohibited. Brokering that involves payment to such individuals or to third parties should also be prohibited.

#### *Commentary on Guiding Principle 6*

This Principle does not affect general advertisements or public appeals to encourage altruistic donation of human cells, tissues or organs, provided that they do not subvert

legally established systems of organ allocation. Instead, it aims to prohibit commercial solicitations, which include offering to pay individuals, the next of kin of deceased persons, or other parties in possession (such as undertakers), for cells, tissues or organs; it targets brokers and other intermediaries as well as direct purchasers.

### **Guiding Principle 7**

Physicians and other health professionals should not engage in transplantation procedures, and health insurers and other payers should not cover such procedures, if the cells, tissues or organs concerned have been obtained through exploitation or coercion of, or payment to, the donor or the next of kin of a deceased donor.

#### *Commentary on Guiding Principle 7*

Health care professionals should only proceed with the removal, intermediate management or implantation of cells, tissues or organs when donations are unpaid and truly voluntary. (In the case of live donors, a psychosocial evaluation of the donor is usually indicated, as described in Guiding Principle 3). Failing to ensure that the person consenting to the donation has not been paid, coerced or exploited breaches professional obligations and should be sanctioned by the relevant professional organizations and government licensing or regulatory authorities.

Physicians and health care facilities should also not refer patients to transplant facilities in their own or other countries that make use of cells, tissues or organs obtained through payments to donors, their families or other vendors or brokers; nor may they seek or accept payment for doing so. Post-transplant care may be provided to patients who have undergone transplantation at such facilities, but physicians who decline to provide such care should not face professional sanctions for such refusals, provided that they refer such patients elsewhere.

Health insurers and other payers should reinforce adherence to high ethical standards by refusing to pay for transplants that violate the Guiding Principles.

### **Guiding Principle 8**

All health care facilities and professionals involved in cell, tissue or organ procurement and transplantation procedures should be prohibited from receiving any payment that exceeds the justifiable fee for the services rendered.

#### *Commentary on Guiding Principle 8*

This provision reinforces Guiding Principles 5 and 7 by forbidding profiteering in cell, tissue and organ recovery and implantation. Health authorities should monitor the fees charged for transplantation services to ensure that they are not disguised charges for the cells, tissues or organs themselves. All persons and facilities involved should be accountable for all payments for transplantation services. A medical or other health care practitioner uncertain whether a fee is justifiable should seek the opinion of an appropriate licensing or disciplinary authority before proposing or levying the fee. Fees charged for similar services may be used as a reference.

### **Guiding Principle 9**

The allocation of organs, cells and tissues should be guided by clinical criteria and ethical norms, not financial or other considerations. Allocation rules, defined by appropriately constituted committees, should be equitable, externally justified, and transparent.

#### *Commentary on Guiding Principle 9*

Where donation rates do not meet clinical demand, allocation criteria should be defined at national or subregional level by a committee that includes experts in the relevant medical specialties, bioethics and public health. Such multidisciplinary is important to ensure that allocation takes into account not only medical factors but also community values and general ethical rules. The criteria for distributing cells, tissues and organs should accord with human rights and, in particular, should not be based on a recipient's gender, race, religion, or economic condition.

This principle implies that the cost of transplantation and follow-up, including immunosuppressive treatment where applicable, should be affordable to all patients concerned – that is, no recipient should be excluded solely for financial reasons.

The concept of transparency is not exclusive to the allocation process but is central to all aspects of transplantation (as is discussed in the commentary on Guiding Principle 11, below).

### **Guiding Principle 10**

High-quality, safe and efficacious procedures are essential for donors and recipients alike. The long-term outcomes of cell, tissue and organ donation and transplantation should be assessed for the living donor as well as the recipient in order to document benefit and harm.

The level of safety, efficacy and quality of human cells, tissues and organs for transplantation, as health products of an exceptional nature, must be maintained and optimized on an ongoing basis. This requires implementation of quality systems including traceability and vigilance, with adverse events and reactions reported, both nationally and for exported human products.

#### *Commentary on Guiding Principle 10*

Optimizing the outcome of cell, tissue and organ transplantation entails a rules-based process that encompasses clinical interventions and ex vivo procedures from donor selection through long-term follow-up. Under the oversight of national health authorities, transplant programmes should monitor both donors and recipients to ensure that they receive appropriate care, including information regarding the transplantation team responsible for their care.

Evaluation of information regarding the long-term risks and benefits is essential to the consent process and for adequately balancing the interests of donors as well as recipients. The benefits to both must outweigh the risks associated with

the donation and transplantation. Donors should not be permitted to donate in clinically hopeless situations.

Donation and transplant programmes are encouraged to participate in national and/or international transplant registries. All deviations from accepted processes that could elevate the risk to recipients or donors, as well as any untoward consequences of donation or transplantation, should be reported to and analysed by responsible health authorities.

Transplantation of human material which does not involve maintenance treatment may not require active, long-term follow-up, though traceability should be ensured for the anticipated lifetime of the donor and the recipient. Internationally agreed means of coding to identify tissues and cells used in transplantation are essential for full traceability.

### **Guiding Principle 11**

The organization and execution of donation and transplantation activities, as well as their clinical results, must be transparent and open to scrutiny, while ensuring that the personal anonymity and privacy of donors and recipients are always protected.

#### *Commentary on Guiding Principle 11*

Transparency can be summarized as maintaining public access to regularly updated comprehensive data on processes, in particular allocation, transplant activities and outcomes for both recipients and living donors, as well as data on organization, budgets and funding. Such transparency is not inconsistent with shielding from public access information that could identify individual donors or recipients while still respecting the necessity of traceability recognized in Principle 10. The objective of the system should be not only to maximize the availability of data for scholarly study and governmental oversight but also to identify risks – and facilitate their correction – in order to minimize harm to donors or recipients.

Available online at:

[http://www.who.int/LinkFiles/BCT\\_WHO\\_guiding\\_principles\\_organ\\_transplantation.pdf](http://www.who.int/LinkFiles/BCT_WHO_guiding_principles_organ_transplantation.pdf)

## 23/WOMEN'S HUMAN RIGHTS

- Convention on the Elimination of All Forms of Discrimination against Women (United Nations, 1979)
- Declaration on the Elimination of Violence against Women (United Nations, 1993)
- Beijing Declaration and Platform for Action: Fourth World Conference on Women (United Nations, 1995)
- Violence against Women (International Federation of Gynecology and Obstetrics, 1995)
- Resolution on Violence against Women (International Federation of Gynecology and Obstetrics, 1997)

### CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

*(United Nations, 1979, entered into force 1981)*

#### **The States Parties to the present Convention,**

**Noting** that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women,

**Noting** that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex,

**Noting** that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men and women to enjoy all economic, social, cultural, civil and political rights,

**Considering** the international conventions concluded under the auspices of the United Nations and the specialized agencies promoting equality of rights of men and women,

**Noting** also the resolutions, declarations and recommendations adopted by the United Nations and the specialized agencies promoting equality of rights of men and women,

**Concerned**, however, that despite these various instruments extensive discrimination against women continues to exist,

**Recalling** that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their

countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,

**Concerned** that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs,

**Convinced** that the establishment of the new international economic order based on equity and justice will contribute significantly towards the promotion of equality between men and women,

**Emphasizing** that the eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women,

**Affirming** that the strengthening of international peace and security, the relaxation of international tension, mutual co-operation among all States irrespective of their social and economic systems, general and complete disarmament, in particular nuclear disarmament under strict and effective international control, the affirmation of the principles of justice, equality and mutual benefit in relations among countries and the realization of the right of peoples under alien and colonial domination and foreign occupation to self-determination and independence, as well as respect for national sovereignty and territorial integrity, will promote social progress and development and as a consequence will contribute to the attainment of full equality between men and women,

**Convinced** that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields,

**Bearing** in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole,

**Aware** that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women,

**Determined** to implement the principles set forth in the Declaration on the Elimination of Discrimination against Women and, for that purpose, to adopt the measures required for the elimination of such discrimination in all its forms and manifestations,

Have agreed on the following:

## **PART I**

### **Article I**

For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise

by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

### **Article 2**

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

- a.** To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;
- b.** To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
- c.** To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
- d.** To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
- e.** To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
- f.** To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
- g.** To repeal all national penal provisions which constitute discrimination against women.

### **Article 3**

States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

### **Article 4**

- 1.** Adoption by States Parties of temporary special measures aimed at accelerating *de facto* equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.
- 2.** Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.

**Article 5**

States Parties shall take all appropriate measures:

- a. 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;
- b. To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

**Article 6**

States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

**PART II****Article 7**

States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right:

- a. To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies;
- b. To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government;
- c. To participate in non-governmental organizations and associations concerned with the public and political life of the country.

**Article 8**

States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.

**Article 9**

1. States Parties shall grant women equal rights with men to acquire, change or retain their nationality. They shall ensure in particular that neither marriage to an alien nor change of nationality by the husband during marriage shall automatically change the nationality of the wife, render her stateless or force upon her the nationality of the husband.
2. States Parties shall grant women equal rights with men with respect to the nationality of their children.

### **PART III**

#### **Article 10**

States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

- a.** The same conditions for career and vocational guidance, for access to studies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas; this equality shall be ensured in pre-school, general, technical, professional and higher technical education, as well as in all types of vocational training;
- b.** Access to the same curricula, the same examinations, teaching staff with qualifications of the same standard and school premises and equipment of the same quality;
- c.** The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;
- d.** The same opportunities to benefit from scholarships and other study grants;
- e.** The same opportunities for access to programmes of continuing education, including adult and functional literacy programmes, particularly those aimed at reducing, at the earliest possible time, any gap in education existing between men and women;
- f.** The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely;
- g.** The same opportunities to participate actively in sports and physical education;
- h.** Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

#### **Article 11**

**1.** States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

- a.** The right to work as an inalienable right of all human beings;
- b.** The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;
- c.** The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;

- d. The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;
  - e. The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;
  - f. The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:
- a. To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
  - b. To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
  - c. To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
  - d. To provide special protection to women during pregnancy in types of work proved to be harmful to them.
3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

### **Article 12**

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

### **Article 13**

States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:

- a. The right to family benefits;
- b. The right to bank loans, mortgages and other forms of financial credit;
- c. The right to participate in recreational activities, sports and all aspects of cultural life.

#### **Article 14**

1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.
2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:
  - a. To participate in the elaboration and implementation of development planning at all levels;
  - b. To have access to adequate health care facilities, including information, counselling and services in family planning;
  - c. To benefit directly from social security programmes;
  - d. To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, *inter alia*, the benefit of all community and extension services, in order to increase their technical proficiency;
  - e. To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;
  - f. To participate in all community activities;
  - g. To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;
  - h. To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

#### **PART IV**

#### **Article 15**

1. States Parties shall accord to women equality with men before the law.
2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.
3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect which is directed at restricting the legal capacity of women shall be deemed null and void.
4. States Parties shall accord to men and women the same rights with regard to the law relating to the movement of persons and the freedom to choose their residence and domicile.

**Article 16**

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

- a. The same right to enter into marriage;
- b. The same right freely to choose a spouse and to enter into marriage only with their free and full consent;
- c. The same rights and responsibilities during marriage and at its dissolution;
- d. The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;
- e. The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;
- f. The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;
- g. The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;
- h. The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

**PART V****Article 17**

1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination against Women (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution and to the representation of the different forms of civilization as well as the principal legal systems.

2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

3. The initial election shall be held six months after the date of the entry into force of the present Convention. At least three months before the date of each election the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within two months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.
4. Elections of the members of the Committee shall be held at a meeting of States Parties convened by the Secretary-General at United Nations Headquarters. At that meeting, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.
5. The members of the Committee shall be elected for a term of four years. However, the terms of nine of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these nine members shall be chosen by lot by the Chairman of the Committee.
6. The election of the five additional members of the Committee shall be held in accordance with the provisions of paragraphs 2, 3 and 4 of this article, following the thirty-fifth ratification or accession. The terms of two of the additional members elected on this occasion shall expire at the end of two years, the names of these two members having been chosen by lot by the Chairman of the Committee.
7. For the filling of casual vacancies, the State Party whose expert has ceased to function as a member of the Committee shall appoint another expert from among its nationals, subject to the approval of the Committee.
8. The members of the Committee shall, with the approval of the General Assembly, receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.
9. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

### **Article 18**

1. States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect:
  - a. Within one year after the entry into force for the State concerned;
  - b. Thereafter at least every four years and further whenever the Committee so requests.
2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

**Article 19**

1. The Committee shall adopt its own rules of procedure.
2. The Committee shall elect its officers for a term of two years.

**Article 20**

1. The Committee shall normally meet for a period of not more than two weeks annually in order to consider the reports submitted in accordance with article 18 of the present Convention.
2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.

**Article 21**

1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.
2. The Secretary-General of the United Nations shall transmit the reports of the Committee to the Commission on the Status of Women for its information.

**Article 22**

The specialized agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their activities. The Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities.

**PART VI****Article 23**

Nothing in the present Convention shall affect any provisions that are more conducive to the achievement of equality between men and women which may be contained:

- a. In the legislation of a State Party; or
- b. In any other international convention, treaty or agreement in force for that State.

**Article 24**

States Parties undertake to adopt all necessary measures at the national level aimed at achieving the full realization of the rights recognized in the present Convention.

**Article 25**

1. The present Convention shall be open for signature by all States.
2. The Secretary-General of the United Nations is designated as the depositary of the present Convention.

3. The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
4. The present Convention shall be open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

#### **Article 26**

1. A request for the revision of the present Convention may be made at any time by any State Party by means of a notification in writing addressed to the Secretary-General of the United Nations.
2. The General Assembly of the United Nations shall decide upon the steps, if any, to be taken in respect of such a request.

#### **Article 27**

1. The present Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.
2. For each State ratifying the present Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

#### **Article 28**

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.
2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.
3. Reservations may be withdrawn at any time by notification to this effect addressed to the Secretary-General of the United Nations, who shall then inform all States thereof. Such notification shall take effect on the date on which it is received.

#### **Article 29**

1. Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on the organization of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.
2. Each State Party may at the time of signature or ratification of the present Convention or accession thereto declare that it does not consider itself bound by paragraph 1 of this article. The other States Parties shall not be bound by that paragraph with respect to any State Party which has made such a reservation.

3. Any State Party which has made a reservation in accordance with paragraph 2 of this article may at any time withdraw that reservation by notification to the Secretary-General of the United Nations.

### Article 30

The present Convention, the Arabic, Chinese, English, French, Russian and Spanish texts of which are equally authentic, shall be deposited with the Secretary-General of the United Nations.

IN WITNESS WHEREOF the undersigned, duly authorized, have signed the present Convention.

Source: G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force Sept. 3, 1981.

Available online at: <http://www.unhchr.ch/html/menu3/b/e1cedaw.htm>

## DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

*(United Nations, 1993)*

### The General Assembly,

**Recognizing** the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings,

**Noting** that those rights and principles are enshrined in international instruments, including the Universal Declaration of Human Rights<sup>1</sup>, the International Covenant on Civil and Political Rights<sup>2</sup>, the International Covenant on Economic, Social and Cultural Rights<sup>3</sup>, the Convention on the Elimination of All Forms of Discrimination against Women<sup>4</sup> and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,<sup>5</sup>

**Recognizing** that effective implementation of the Convention on the Elimination of All Forms of Discrimination against Women would contribute to the elimination of violence against women and that the Declaration on the Elimination of Violence against Women, set forth in the present resolution, will strengthen and complement that process,

**Concerned** that violence against women is an obstacle to the achievement of equality, development and peace, as recognized in the Nairobi Forward-looking

---

1. Resolution 217 A (III).

2. See resolution 2200 A (XXI), annex.

3. See resolution 2200 A (XXI), annex.

4. Resolution 34/180, annex.

5. Resolution 39/46, annex.

Strategies for the Advancement of Women<sup>6</sup>, in which a set of measures to combat violence against women was recommended, and to the full implementation of the Convention on the Elimination of All Forms of Discrimination against Women,

**Affirming** that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms, and concerned about the long-standing failure to protect and promote those rights and freedoms in the case of violence against women,

**Recognizing** that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men,

**Concerned** that some groups of women, such as women belonging to minority groups, indigenous women, refugee women, migrant women, women living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women and women in situations of armed conflict, are especially vulnerable to violence,

**Recalling** the conclusion in paragraph 23 of the annex to Economic and Social Council resolution 1990/15 of 24 May 1990 that the recognition that violence against women in the family and society was pervasive and cut across lines of income, class and culture had to be matched by urgent and effective steps to eliminate its incidence,

**Recalling** also Economic and Social Council resolution 1991/18 of 30 May 1991, in which the Council recommended the development of a framework for an international instrument that would address explicitly the issue of violence against women,

**Welcoming** the role that women's movements are playing in drawing increasing attention to the nature, severity and magnitude of the problem of violence against women,

**Alarmed** that opportunities for women to achieve legal, social, political and economic equality in society are limited, *inter alia*, by continuing and endemic violence,

**Convinced** that in the light of the above there is a need for a clear and comprehensive definition of violence against women, a clear statement of the rights to be applied to ensure the elimination of violence against women in all its forms, a commitment by States in respect of their responsibilities, and a commitment by the international community at large to the elimination of violence against women,

**Solemnly proclaims** the following Declaration on the Elimination of Violence against Women and urges that every effort be made so that it becomes generally known and respected:

### Article 1

For the purposes of this Declaration, the term "violence against women" means any

---

6. Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, 15-26 July 1985 (United Nations publication, Sales No. E.85.IV.10), chap. I, sect. A.

act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

## Article 2

Violence against women shall be understood to encompass, but not be limited to, the following:

- a. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

## Article 3

Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, *inter alia*:

- a. The right to life;<sup>7</sup>
- b. The right to equality;<sup>8</sup>
- c. The right to liberty and security of person;<sup>9</sup>
- d. The right to equal protection under the law;<sup>10</sup>
- e. The right to be free from all forms of discrimination;<sup>11</sup>
- f. The right to the highest standard attainable of physical and mental health;<sup>12</sup>
- g. The right to just and favourable conditions of work;<sup>13</sup>
- h. The right not to be subjected to torture, or other cruel, inhuman or degrading treatment or punishment.<sup>14</sup>

---

7. Universal Declaration of Human Rights, article 3; and International Covenant on Civil and Political Rights, article 6.

8. International Covenant on Civil and Political Rights, article 26.

9. Universal Declaration of Human Rights, article 3; and International Covenant on Civil and Political Rights, article 9.

10. International Covenant on Civil and Political Rights, article 26.

11. International Covenant on Civil and Political Rights, article 26.

12. International Covenant on Economic, Social and Cultural Rights, article 12.

13. Universal Declaration of Human Rights, article 23; and International Covenant on Economic, Social and Cultural Rights, articles 6 and 7.

14. Universal Declaration of Human Rights, article 5; International Covenant on Civil and Political Rights, article 7; and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

#### **Article 4**

States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women and, to this end, should:

- a.** Consider, where they have not yet done so, ratifying or acceding to the Convention on the Elimination of All Forms of Discrimination against Women or withdrawing reservations to that Convention;
- b.** Refrain from engaging in violence against women;
- c.** Exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons;
- d.** Develop penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs caused to women who are subjected to violence; women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered; States should also inform women of their rights in seeking redress through such mechanisms;
- e.** Consider the possibility of developing national plans of action to promote the protection of women against any form of violence, or to include provisions for that purpose in plans already existing, taking into account, as appropriate, such cooperation as can be provided by non-governmental organizations, particularly those concerned with the issue of violence against women;
- f.** Develop, in a comprehensive way, preventive approaches and all those measures of a legal, political, administrative and cultural nature that promote the protection of women against any form of violence, and ensure that the re-victimization of women does not occur because of laws insensitive to gender considerations, enforcement practices or other interventions;
- g.** Work to ensure, to the maximum extent feasible in the light of their available resources and, where needed, within the framework of international cooperation, that women subjected to violence and, where appropriate, their children have specialized assistance, such as rehabilitation, assistance in child care and maintenance, treatment, counselling, and health and social services, facilities and programmes, as well as support structures, and should take all other appropriate measures to promote their safety and physical and psychological rehabilitation;
- h.** Include in government budgets adequate resources for their activities related to the elimination of violence against women;
- i.** Take measures to ensure that law enforcement officers and public officials responsible for implementing policies to prevent, investigate and punish violence against women receive training to sensitize them to the needs of women;

- j.** Adopt all appropriate measures, especially in the field of education, to modify the social and cultural patterns of conduct of men and women and to eliminate prejudices, customary practices and all other practices based on the idea of the inferiority or superiority of either of the sexes and on stereotyped roles for men and women;
- k.** Promote research, collect data and compile statistics, especially concerning domestic violence, relating to the prevalence of different forms of violence against women and encourage research on the causes, nature, seriousness and consequences of violence against women and on the effectiveness of measures implemented to prevent and redress violence against women; those statistics and findings of the research will be made public;
- l.** Adopt measures directed towards the elimination of violence against women who are especially vulnerable to violence;
- m.** Include, in submitting reports as required under relevant human rights instruments of the United Nations, information pertaining to violence against women and measures taken to implement the present Declaration;
- n.** Encourage the development of appropriate guidelines to assist in the implementation of the principles set forth in the present Declaration;
- o.** Recognize the important role of the women's movement and non-governmental organizations world wide in raising awareness and alleviating the problem of violence against women;
- p.** Facilitate and enhance the work of the women's movement and non-governmental organizations and cooperate with them at local, national and regional levels;
- q.** Encourage intergovernmental regional organizations of which they are members to include the elimination of violence against women in their programmes, as appropriate.

### **Article 5**

The organs and specialized agencies of the United Nations system should, within their respective fields of competence, contribute to the recognition and realization of the rights and the principles set forth in the present Declaration and, to this end, should, *inter alia*:

- a.** Foster international and regional cooperation with a view to defining regional strategies for combating violence, exchanging experiences and financing programmes relating to the elimination of violence against women;
- b.** Promote meetings and seminars with the aim of creating and raising awareness among all persons of the issue of the elimination of violence against women;
- c.** Foster coordination and exchange within the United Nations system between human rights treaty bodies to address the issue of violence against women effectively;

- d. Include in analyses prepared by organizations and bodies of the United Nations system of social trends and problems, such as the periodic reports on the world social situation, examination of trends in violence against women;
- e. Encourage coordination between organizations and bodies of the United Nations system to incorporate the issue of violence against women into ongoing programmes, especially with reference to groups of women particularly vulnerable to violence;
- f. Promote the formulation of guidelines or manuals relating to violence against women, taking into account the measures referred to in the present Declaration;
- g. Consider the issue of the elimination of violence against women, as appropriate, in fulfilling their mandates with respect to the implementation of human rights instruments;
- h. Cooperate with non-governmental organizations in addressing the issue of violence against women.

### Article 6

Nothing in the present Declaration shall affect any provision that is more conducive to the elimination of violence against women that may be contained in the legislation of a State or in any international convention, treaty or other instrument in force in a State.

General Assembly resolution 48/104 of 20 December 1993

Available online at:

[http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En)

## BEIJING DECLARATION AND PLATFORM FOR ACTION FOURTH WORLD CONFERENCE ON WOMEN

*(United Nations, 1995)*

1. We, the Governments participating in the Fourth World Conference on Women,
2. Gathered here in Beijing in September 1995, the year of the fiftieth anniversary of the founding of the United Nations,
3. Determined to advance the goals of equality, development and peace for all women everywhere in the interest of all humanity,
4. Acknowledging the voices of all women everywhere and taking note of the diversity of women and their roles and circumstances, honouring the women who paved the way and inspired by the hope present in the world's youth,
5. Recognize that the status of women has advanced in some important respects in the past decade but that progress has been uneven, inequalities between women and men have persisted and major obstacles remain, with serious consequences for the well-being of all people,
6. Also recognize that this situation is exacerbated by the increasing poverty that is affecting the lives of the majority of the world's people, in particular women and children, with origins in both the national and international domains,

7. Dedicate ourselves unreservedly to addressing these constraints and obstacles and thus enhancing further the advancement and empowerment of women all over the world, and agree that this requires urgent action in the spirit of determination, hope, cooperation and solidarity, now and to carry us forward into the next century.

**We reaffirm our commitment to:**

8. The equal rights and inherent human dignity of women and men and other purposes and principles enshrined in the Charter of the United Nations, to the Universal Declaration of Human Rights and other international human rights instruments, in particular the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, as well as the Declaration on the Elimination of Violence against Women and the Declaration on the Right to Development;

9. Ensure the full implementation of the human rights of women and of the girl child as an inalienable, integral and indivisible part of all human rights and fundamental freedoms;

10. Build on consensus and progress made at previous United Nations conferences and summits – on women in Nairobi in 1985, on children in New York in 1990, on environment and development in Rio de Janeiro in 1992, on human rights in Vienna in 1993, on population and development in Cairo in 1994 and on social development in Copenhagen in 1995 with the objective of achieving equality, development and peace;

11. Achieve the full and effective implementation of the Nairobi Forward-looking Strategies for the Advancement of Women;

12. The empowerment and advancement of women, including the right to freedom of thought, conscience, religion and belief, thus contributing to the moral, ethical, spiritual and intellectual needs of women and men, individually or in community with others and thereby guaranteeing them the possibility of realizing their full potential in society and shaping their lives in accordance with their own aspirations.

**We are convinced that:**

13. Women's empowerment and their full participation on the basis of equality in all spheres of society, including participation in the decision-making process and access to power, are fundamental for the achievement of equality, development and peace;

14. Women's rights are human rights;

15. Equal rights, opportunities and access to resources, equal sharing of responsibilities for the family by men and women, and a harmonious partnership between them are critical to their well-being and that of their families as well as to the consolidation of democracy;

16. Eradication of poverty based on sustained economic growth, social development, environmental protection and social justice requires the involvement

of women in economic and social development, equal opportunities and the full and equal participation of women and men as agents and beneficiaries of people-centred sustainable development;

**17.** The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment;

**18.** Local, national, regional and global peace is attainable and is inextricably linked with the advancement of women, who are a fundamental force for leadership, conflict resolution and the promotion of lasting peace at all levels;

**19.** It is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes, including development policies and programmes, at all levels that will foster the empowerment and advancement of women;

**20.** The participation and contribution of all actors of civil society, particularly women's groups and networks and other non-governmental organizations and community-based organizations, with full respect for their autonomy, in cooperation with Governments, are important to the effective implementation and follow-up of the Platform for Action;

**21.** The implementation of the Platform for Action requires commitment from Governments and the international community. By making national and international commitments for action, including those made at the Conference, Governments and the international community recognize the need to take priority action for the empowerment and advancement of women.

**We are determined to:**

**22.** Intensify efforts and actions to achieve the goals of the Nairobi Forward-looking Strategies for the Advancement of Women by the end of this century;

**23.** Ensure the full enjoyment by women and the girl child of all human rights and fundamental freedoms and take effective action against violations of these rights and freedoms;

**24.** Take all necessary measures to eliminate all forms of discrimination against women and the girl child and remove all obstacles to gender equality and the advancement and empowerment of women;

**25.** Encourage men to participate fully in all actions towards equality;

**26.** Promote women's economic independence, including employment, and eradicate the persistent and increasing burden of poverty on women by addressing the structural causes of poverty through changes in economic structures, ensuring equal access for all women, including those in rural areas, as vital development agents, to productive resources, opportunities and public services;

**27.** Promote people-centred sustainable development, including sustained economic growth, through the provision of basic education, life-long education, literacy and training, and primary health care for girls and women;

**28.** Take positive steps to ensure peace for the advancement of women and, recognizing the leading role that women have played in the peace movement, work

actively towards general and complete disarmament under strict and effective international control, and support negotiations on the conclusion, without delay, of a universal and multilaterally and effectively verifiable comprehensive nuclear-test-ban treaty which contributes to nuclear disarmament and the prevention of the proliferation of nuclear weapons in all its aspects;

- 29. Prevent and eliminate all forms of violence against women and girls;
- 30. Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education;
- 31. Promote and protect all human rights of women and girls;
- 32. Intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people;
- 33. Ensure respect for international law, including humanitarian law, in order to protect women and girls in particular;
- 34. Develop the fullest potential of girls and women of all ages, ensure their full and equal participation in building a better world for all and enhance their role in the development process.

**We are determined to:**

- 35. Ensure women's equal access to economic resources, including land, credit, science and technology, vocational training, information, communication and markets, as a means to further the advancement and empowerment of women and girls, including through the enhancement of their capacities to enjoy the benefits of equal access to these resources, *inter alia*, by means of international cooperation;
- 36. Ensure the success of the Platform for Action, which will require a strong commitment on the part of Governments, international organizations and institutions at all levels. We are deeply convinced that economic development, social development and environmental protection are interdependent and mutually reinforcing components of sustainable development, which is the framework for our efforts to achieve a higher quality of life for all people. Equitable social development that recognizes empowering the poor, particularly women living in poverty, to utilize environmental resources sustainably is a necessary foundation for sustainable development. We also recognize that broad-based and sustained economic growth in the context of sustainable development is necessary to sustain social development and social justice. The success of the Platform for Action will also require adequate mobilization of resources at the national and international levels as well as new and additional resources to the developing countries from all available funding mechanisms, including multilateral, bilateral and private sources for the advancement of women; financial resources to strengthen the capacity of national, subregional, regional and international institutions; a commitment to equal rights, equal responsibilities and equal opportunities and to the equal participation of

women and men in all national, regional and international bodies and policy-making processes; and the establishment or strengthening of mechanisms at all levels for accountability to the world's women;

**37.** Ensure also the success of the Platform for Action in countries with economies in transition, which will require continued international cooperation and assistance;

**38.** We hereby adopt and commit ourselves as Governments to implement the following Platform for Action, ensuring that a gender perspective is reflected in all our policies and programmes. We urge the United Nations system, regional and international financial institutions, other relevant regional and international institutions and all women and men, as well as non-governmental organizations, with full respect for their autonomy, and all sectors of civil society, in cooperation with Governments, to fully commit themselves and contribute to the implementation of this Platform for Action

## **BEIJING PLATFORM FOR ACTION CHAPTER IV: STRATEGIC OBJECTIVES AND ACTIONS**

### **C. Women and Health<sup>1</sup>**

**89.** Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well-being elude the majority of women. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups. In national and international forums, women have emphasized that to attain optimal health throughout the life cycle, equality, including the sharing of family responsibilities, development and peace are necessary conditions.

**90.** Women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others. Women also have different and unequal opportunities for the protection, promotion and maintenance of their health. In many developing countries, the lack of emergency obstetric services is also of particular concern. Health policies and programmes often perpetuate gender stereotypes and fail to consider socio-

---

1. Other sections of this plan of action have been omitted for reasons of space. These can be obtained at: <http://www.un.org/esa/gopher-data/conf/fwcw/off/a-20.en>

economic disparities and other differences among women and may not fully take account of the lack of autonomy of women regarding their health. Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women.

**91.** In many countries, especially developing countries, in particular the least developed countries, a decrease in public health spending and, in some cases, structural adjustment, contribute to the deterioration of public health systems. In addition, privatization of health-care systems without appropriate guarantees of universal access to affordable health care further reduces health-care availability. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women, whose multiple roles, including their roles within the family and the community, are often not acknowledged; hence they do not receive the necessary social, psychological and economic support.

**92.** Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural and poor urban areas, and deficient housing conditions, all overburden women and their families and have a negative effect on their health. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.

**93.** Discrimination against girls, often resulting from son preference, in access to nutrition and health-care services endangers their current and future health and well-being. Conditions that force girls into early marriage, pregnancy and child-bearing and subject them to harmful practices, such as female genital mutilation, pose grave health risks. Adolescent girls need, but too often do not have, access to necessary health and nutrition services as they mature. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking completely, and a young woman's right to privacy, confidentiality, respect and informed consent is often not considered. Adolescent girls are both biologically and psychosocially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. The trend towards early sexual experience, combined with a lack of information and services, increases the risk of unwanted and too early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world.

Overall, for young women early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on the quality of their lives and the lives of their children. Young men are often not educated to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

**94.** Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

**95.** Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the

limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

**96.** The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

**97.** Further, women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. Complications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world. Similar problems exist to a certain degree in some countries with economies in transition. Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services, including safe and effective family planning methods and emergency obstetric care, recognizing the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. These problems and means should be addressed on the basis of the report of the International Conference on Population and Development, with particular reference to relevant paragraphs of the Programme of Action of the Conference. [14] In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. Shared responsibility between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health.

**98.** HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Women, who represent half of all adults newly infected with HIV/AIDS and other sexually transmitted diseases, have emphasized that social vulnerability and the unequal power relationships between women and men are obstacles to safe sex, in their efforts to control the spread of sexually transmitted diseases. The consequences of

HIV/AIDS reach beyond women's health to their role as mothers and caregivers and their contribution to the economic support of their families. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective.

**99.** Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. Such situations often deter women from using health and other services.

**100.** Mental disorders related to marginalization, powerlessness and poverty, along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women. Women throughout the world, especially young women, are increasing their use of tobacco with serious effects on their health and that of their children. Occupational health issues are also growing in importance, as a large number of women work in low-paid jobs in either the formal or the informal labour market under tedious and unhealthy conditions, and the number is rising. Cancers of the breast and cervix and other cancers of the reproductive system, as well as infertility affect growing numbers of women and may be preventable, or curable, if detected early.

**101.** With the increase in life expectancy and the growing number of older women, their health concerns require particular attention. The long-term health prospects of women are influenced by changes at menopause, which, in combination with life-long conditions and other factors, such as poor nutrition and lack of physical activity, may increase the risk of cardiovascular disease and osteoporosis. Other diseases of ageing and the interrelationships of ageing and disability among women also need particular attention.

**102.** Women, like men, particularly in rural areas and poor urban areas, are increasingly exposed to environmental health hazards owing to environmental catastrophes and degradation. Women have a different susceptibility to various environmental hazards, contaminants and substances and they suffer different consequences from exposure to them.

**103.** The quality of women's health care is often deficient in various ways, depending on local circumstances. Women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available. Furthermore, in some countries, over-medicating of women's life events is common, leading to unnecessary surgical intervention and inappropriate medication.

**104.** Statistical data on health are often not systematically collected, disaggregated and analysed by age, sex and socio-economic status and by established demographic criteria used to serve the interests and solve the problems of subgroups, with particular emphasis on the vulnerable and marginalized and other relevant variables. Recent and reliable data on the mortality and morbidity of women and conditions and diseases particularly affecting women are not available in many

countries. Relatively little is known about how social and economic factors affect the health of girls and women of all ages, about the provision of health services to girls and women and the patterns of their use of such services, and about the value of disease prevention and health promotion programmes for women. Subjects of importance to women's health have not been adequately researched and women's health research often lacks funding. Medical research, on heart disease, for example, and epidemiological studies in many countries are often based solely on men; they are not gender specific. Clinical trials involving women to establish basic information about dosage, side-effects and effectiveness of drugs, including contraceptives, are noticeably absent and do not always conform to ethical standards for research and testing. Many drug therapy protocols and other medical treatments and interventions administered to women are based on research on men without any investigation and adjustment for gender differences.

**105.** In addressing inequalities in health status and unequal access to and inadequate health-care services between women and men, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively.

**Strategic objective C.1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services**

*Actions to be taken:*

**106.** By Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions:

- a.** Support and implement the commitments made in the Programme of Action of the International Conference on Population and Development, as established in the report of that Conference and the Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development [15] and the obligations of States parties under the Convention on the Elimination of All Forms of Discrimination against Women and other relevant international agreements, to meet the health needs of girls and women of all ages;
- b.** Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, for example; review existing legislation, including health legislation, as well as policies, where necessary, to reflect a commitment to women's health and to ensure that they meet the changing roles and responsibilities of women wherever they reside;
- c.** Design and implement, in cooperation with women and community-based organizations, gender-sensitive health programmes, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with

disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, especially local and indigenous women, in the identification and planning of health-care priorities and programmes; remove all barriers to women's health services and provide a broad range of health-care services;

**d.** Allow women access to social security systems in equality with men throughout the whole life cycle;

**e.** Provide more accessible, available and affordable primary health-care services of high quality, including sexual and reproductive health care, which includes family planning information and services, and giving particular attention to maternal and emergency obstetric care, as agreed to in the Programme of Action of the International Conference on Population and Development;

**f.** Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality; these services, information and training should be based on a holistic approach;

**g.** Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent; encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health professionals;

**h.** Take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions, as well as inappropriate medication and over-medication of women, and ensure that all women are fully informed of their options, including likely benefits and potential side-effects, by properly trained personnel;

**i.** Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls; reduce ill health and maternal morbidity and achieve world wide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015; ensure that the necessary services are available at each level of the health system and make reproductive health care accessible, through the primary health-care system, to all individuals of appropriate ages as soon as possible and no later than the year 2015;

**j.** Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development; [14]

**k.** In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, which states: "In no case should abortion be promoted as a method of family planning. All

Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion [16] as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions", consider reviewing laws containing punitive measures against women who have undergone illegal abortions;

- i.** Give particular attention to the needs of girls, especially the promotion of healthy behaviour, including physical activities; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving internationally approved goals for the reduction of infant and child mortality – specifically, by the year 2000, the reduction of mortality rates of infants and children under five years of age by one third of the 1990 level, or 50 to 70 per 1,000 live births, whichever is less; by the year 2015 an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000;
- m.** Ensure that girls have continuing access to necessary health and nutrition information and services as they mature, to facilitate a healthful transition from childhood to adulthood;
- n.** Develop information, programmes and services to assist women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women, paying particular attention to those who are physically or psychologically dependent;
- o.** Ensure that girls and women of all ages with any form of disability receive supportive services;
- p.** Formulate special policies, design programmes and enact the legislation necessary to alleviate and eliminate environmental and occupational health hazards associated with work in the home, in the workplace and elsewhere with attention to pregnant and lactating women;
- q.** Integrate mental health services into primary health-care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict;

- r. Promote public information on the benefits of breast-feeding; examine ways and means of implementing fully the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes, and enable mothers to breast-feed their infants by providing legal, economic, practical and emotional support;
- s. Establish mechanisms to support and involve non-governmental organizations, particularly women's organizations, professional groups and other bodies working to improve the health of girls and women, in government policy-making, programme design, as appropriate, and implementation within the health sector and related sectors at all levels;
- t. Support non-governmental organizations working on women's health and help develop networks aimed at improving coordination and collaboration between all sectors that affect health;
- u. Rationalize drug procurement and ensure a reliable, continuous supply of high-quality pharmaceutical, contraceptive and other supplies and equipment, using the WHO Model List of Essential Drugs as a guide, and ensure the safety of drugs and devices through national regulatory drug approval processes;
- v. Provide improved access to appropriate treatment and rehabilitation services for women substance abusers and their families;
- w. Promote and ensure household and national food security, as appropriate, and implement programmes aimed at improving the nutritional status of all girls and women by implementing the commitments made in the Plan of Action on Nutrition of the International Conference on Nutrition, [17] including a reduction world wide of severe and moderate malnutrition among children under the age of five by one half of 1990 levels by the year 2000, giving special attention to the gender gap in nutrition, and a reduction in iron deficiency anaemia in girls and women by one third of the 1990 levels by the year 2000;
- x. Ensure the availability of and universal access to safe drinking water and sanitation and put in place effective public distribution systems as soon as possible;
- y. Ensure full and equal access to health-care infrastructure and services for indigenous women.

**Strategic objective C.2. Strengthen preventive programmes that promote women's health**

*Actions to be taken:*

**107.** By Governments, in cooperation with non-governmental organizations, the mass media, the private sector and relevant international organizations, including United Nations bodies, as appropriate:

- a. Give priority to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, achieve mutual

respect in matters concerning sexuality and fertility and educate men regarding the importance of women's health and well-being, placing special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including female genital mutilation, son preference (which results in female infanticide and prenatal sex selection), early marriage, including child marriage, violence against women, sexual exploitation, sexual abuse, which at times is conducive to infection with HIV/AIDS and other sexually transmitted diseases, drug abuse, discrimination against girls and women in food allocation and other harmful attitudes and practices related to the life, health and well-being of women, and recognizing that some of these practices can be violations of human rights and ethical medical principles;

**b.** Pursue social, human development, education and employment policies to eliminate poverty among women in order to reduce their susceptibility to ill health and to improve their health;

**c.** Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them;

**d.** Reinforce laws, reform institutions and promote norms and practices that eliminate discrimination against women and encourage both women and men to take responsibility for their sexual and reproductive behaviour; ensure full respect for the integrity of the person, take action to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices;

**e.** Prepare and disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction, taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as the responsibilities, rights and duties of parents and legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child, and in conformity with the Convention on the Elimination of All Forms of Discrimination against Women; ensure that in all actions concerning children, the best interests of the child are a primary consideration;

**f.** Create and support programmes in the educational system, in the workplace and in the community to make opportunities to participate in sport, physical activity and recreation available to girls and women of all ages on the same basis as they are made available to men and boys;

**g.** Recognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and

reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph 107 (e) above;

**h.** Develop policies that reduce the disproportionate and increasing burden on women who have multiple roles within the family and the community by providing them with adequate support and programmes from health and social services;

**i.** Adopt regulations to ensure that the working conditions, including remuneration and promotion of women at all levels of the health system, are non-discriminatory and meet fair and professional standards to enable them to work effectively;

**j.** Ensure that health and nutritional information and training form an integral part of all adult literacy programmes and school curricula from the primary level;

**k.** Develop and undertake media campaigns and information and educational programmes that inform women and girls of the health and related risks of substance abuse and addiction and pursue strategies and programmes that discourage substance abuse and addiction and promote rehabilitation and recovery;

**l.** Devise and implement comprehensive and coherent programmes for the prevention, diagnosis and treatment of osteoporosis, a condition that predominantly affects women;

**m.** Establish and/or strengthen programmes and services, including media campaigns, that address the prevention, early detection and treatment of breast, cervical and other cancers of the reproductive system;

**n.** Reduce environmental hazards that pose a growing threat to health, especially in poor regions and communities; apply a precautionary approach, as agreed to in the Rio Declaration on Environment and Development, adopted by the United Nations Conference on Environment and Development, [18] and include reporting on women's health risks related to the environment in monitoring the implementation of Agenda 21; [19]

**o.** Create awareness among women, health professionals, policy makers and the general public about the serious but preventable health hazards stemming from tobacco consumption and the need for regulatory and education measures to reduce smoking as important health promotion and disease prevention activities;

**p.** Ensure that medical school curricula and other health-care training include gender-sensitive, comprehensive and mandatory courses on women's health;

**q.** Adopt specific preventive measures to protect women, youth and children from any abuse – sexual abuse, exploitation, trafficking and violence, for example – including the formulation and enforcement of laws, and provide legal protection and medical and other assistance.

**Strategic objective C.3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues**

*Actions to be taken:*

**108.** By Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors and non-governmental organizations:

- a.** Ensure the involvement of women, especially those infected with HIV/AIDS or other sexually transmitted diseases or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other sexually transmitted diseases;
- b.** Review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it, and implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS;
- c.** Encourage all sectors of society, including the public sector, as well as international organizations, to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals;
- d.** Recognize the extent of the HIV/AIDS pandemic in their countries, taking particularly into account its impact on women, with a view to ensuring that infected women do not suffer stigmatization and discrimination, including during travel;
- e.** Develop gender-sensitive multi-sectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality; facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases;
- f.** Facilitate the development of community strategies that will protect women of all ages from HIV and other sexually transmitted diseases; provide care and support to infected girls, women and their families and mobilize all parts of the community in response to the HIV/AIDS pandemic to exert pressure on all responsible authorities to respond in a timely, effective, sustainable and gender-sensitive manner;
- g.** Support and strengthen national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS and other sexually transmitted diseases, including the provision of resources and facilities to women who find themselves the principal caregivers or economic support for those infected with HIV/AIDS or affected by the pandemic, and the survivors, particularly children and older persons;

- h.** Provide workshops and specialized education and training to parents, decision makers and opinion leaders at all levels of the community, including religious and traditional authorities, on prevention of HIV/AIDS and other sexually transmitted diseases and on their repercussions on both women and men of all ages;
- i.** Give all women and health workers all relevant information and education about sexually transmitted diseases including HIV/AIDS and pregnancy and the implications for the baby, including breast-feeding;
- j.** Assist women and their formal and informal organizations to establish and expand effective peer education and outreach programmes and to participate in the design, implementation and monitoring of these programmes;
- k.** Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;
- l.** Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour, including voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through, *inter alia*, abstinence and condom use;
- m.** Ensure the provision, through the primary health-care system, of universal access of couples and individuals to appropriate and affordable preventive services with respect to sexually transmitted diseases, including HIV/AIDS, and expand the provision of counselling and voluntary and confidential diagnostic and treatment services for women; ensure that high-quality condoms as well as drugs for the treatment of sexually transmitted diseases are, where possible, supplied and distributed to health services;
- n.** Support programmes which acknowledge that the higher risk among women of contracting HIV is linked to high-risk behaviour, including intravenous substance use and substance-influenced unprotected and irresponsible sexual behaviour, and take appropriate preventive measures;
- o.** Support and expedite action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research;
- p.** Support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female risk-taking attitudes and practices.

### **Strategic objective C.4. Promote research and disseminate information on women's health**

*Actions to be taken:*

**109** By Governments, the United Nations system, health professions, research institutions, non-governmental organizations, donors, pharmaceutical industries and the mass media, as appropriate:

- a.** Train researchers and introduce systems that allow for the use of data collected, analysed and disaggregated by, among other factors, sex and age, other established demographic criteria and socio-economic variables, in policy-making, as appropriate, planning, monitoring and evaluation;
- b.** Promote gender-sensitive and women-centred health research, treatment and technology and link traditional and indigenous knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions;
- c.** Increase the number of women in leadership positions in the health professions, including researchers and scientists, to achieve equality at the earliest possible date;
- d.** Increase financial and other support from all sources for preventive, appropriate biomedical, behavioural, epidemiological and health service research on women's health issues and for research on the social, economic and political causes of women's health problems, and their consequences, including the impact of gender and age inequalities, especially with respect to chronic and non-communicable diseases, particularly cardiovascular diseases and conditions, cancers, reproductive tract infections and injuries, HIV/AIDS and other sexually transmitted diseases, domestic violence, occupational health, disabilities, environmentally related health problems, tropical diseases and health aspects of ageing;
- e.** Inform women about the factors which increase the risks of developing cancers and infections of the reproductive tract, so that they can make informed decisions about their health;
- f.** Support and fund social, economic, political and cultural research on how gender-based inequalities affect women's health, including etiology, epidemiology, provision and utilization of services and eventual outcome of treatment;
- g.** Support health service systems and operations research to strengthen access and improve the quality of service delivery, to ensure appropriate support for women as health-care providers and to examine patterns with respect to the provision of health services to women and use of such services by women;
- h.** Provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable methods for the regulation of fertility, including natural family

planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases, among others; this research needs to be guided at all stages by users and from the perspective of gender, particularly the perspective of women, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research;

- i. Since unsafe abortion [16] is a major threat to the health and life of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care;
- j. Acknowledge and encourage beneficial traditional health care, especially that practised by indigenous women, with a view to preserving and incorporating the value of traditional health care in the provision of health services, and support research directed towards achieving this aim;
- k. Develop mechanisms to evaluate and disseminate available data and research findings to researchers, policy makers, health professionals and women's groups, among others;
- l. Monitor human genome and related genetic research from the perspective of women's health and disseminate information and results of studies conducted in accordance with accepted ethical standards.

**Strategic objective C.5. Increase resources and monitor follow-up for women's health**

*Actions to be taken:*

**110.** By Governments at all levels and, where appropriate, in cooperation with non-governmental organizations, especially women's and youth organizations:

- a. Increase budgetary allocations for primary health care and social services, with adequate support for secondary and tertiary levels, and give special attention to the reproductive and sexual health of girls and women and give priority to health programmes in rural and poor urban areas;
- b. Develop innovative approaches to funding health services through promoting community participation and local financing; increase, where necessary, budgetary allocations for community health centres and community-based programmes and services that address women's specific health needs;
- c. Develop local health services, promoting the incorporation of gender-sensitive community-based participation and self-care and specially designed preventive health programmes;
- d. Develop goals and time-frames, where appropriate, for improving women's health and for planning, implementing, monitoring and evaluating

programmes, based on gender-impact assessments using qualitative and quantitative data disaggregated by sex, age, other established demographic criteria and socio-economic variables;

e. Establish, as appropriate, ministerial and inter-ministerial mechanisms for monitoring the implementation of women's health policy and programme reforms and establish, as appropriate, high-level focal points in national planning authorities responsible for monitoring to ensure that women's health concerns are mainstreamed in all relevant government agencies and programmes.

**111.** By Governments, the United Nations and its specialized agencies, international financial institutions, bilateral donors and the private sector, as appropriate:

- a. Formulate policies favourable to investment in women's health and, where appropriate, increase allocations for such investment;
- b. Provide appropriate material, financial and logistical assistance to youth non-governmental organizations in order to strengthen them to address youth concerns in the area of health, including sexual and reproductive health;
- c. Give higher priority to women's health and develop mechanisms for coordinating and implementing the health objectives of the Platform for Action and relevant international agreements to ensure progress.

### **C. Women and Health – Notes**

[14] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[15] Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995 (A/CONF.166/9), chap. I, resolution 1, annexes I and II.

[16] Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on World Health Organization, *The Prevention and Management of Unsafe Abortion*, Report of a Technical Working Group, Geneva, April 1992 (WHO/MSM/92.5)).

[17] Final Report of the International Conference on Nutrition, Rome, 5–11 December 1992 (Rome, Food and Agriculture Organization of the United Nations, 1993), Part II.

[18] Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992, vol. I, Resolutions Adopted by the Conference (United Nations publication, Sales No. E.93.I.8 and corrigenda), resolution 1, annex I.

[19] *Ibid.*, resolution 1, annex II.

Report of the Fourth World Conference on Women, Beijing, China 4-15 September 1995, Action for Equality, Development and Peace, UN Document A/CONF.177/20, 17 October 1995.

Available online at: <http://www.un.org/esa/gopher-data/conf/fwcw/off/a> – 20.en

## VIOLENCE AGAINST WOMEN

*(International Federation of Gynecology and Obstetrics, 1995)*

1. Violence against women is one reflection of the unequal power relationship of men and women in societies. Reflections of this inequality include marriage at a very young age, lack of information or choice about fertility control and forced pregnancy within marriage.
2. Violence against women is condemned, whether it occurs in a societal setting (such as female genital mutilation) or a domestic setting (such as spousal abuse). It is not a private or family matter. Violence against women is not acceptable whatever the setting and therefore physicians treating women are ethically obligated to:
  - i. Inform themselves about the manifestations of violence and recognise cases. Documentation must take into account the need for confidentiality to avoid potential harmful consequences for the woman, and this may need separate, non-identifiable compilation of data.
  - ii. Treat the physical and psychological results of the violence.
  - iii. Affirm to their patients that violent acts towards them are not acceptable.
  - iv. Advocate for social infrastructures to provide women the choice of seeking secure refuge and ongoing counselling.
3. The physical, financial and social vulnerabilities of women are fundamentally harmful to the future of a society. Not redressing them fails to prevent harm to subsequent generations and contributes to the cycle of violence. Physicians treating women therefore have an obligation to:
  - i. Affirm women's right to be free of physical and psychological violence, particularly sexual violence, examples of which range from war crimes in conflicts between states to sexual intercourse without consent within marriage.
  - ii. Advocate for non-violent resolutions in relationships by enlisting the aid of social workers and other health care workers where appropriate.
  - iii. Make themselves, and others, aware of the harmful effects of the embedded discrimination against women in social systems.
4. There is a need for wider awareness of the magnitude of the problem of violence against women. Physicians are uniquely placed to assist in this. Only if a problem is recognised can it be addressed. There is therefore a duty for professional societies and physicians to publicize information about the frequency of types of violence against women.

Adopted, Jerusalem, 1995.

From *Ethical Issues in Obstetrics and Gynecology* by the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. FIGO, November 2006.

Available online at: <http://www.figo.org/docs/ethics%20Guidelines.pdf>

## RESOLUTION ON VIOLENCE AGAINST WOMEN

*(International Federation of Gynecology and Obstetrics, 1997)*

### **The FIGO General Assembly,**

**Considering** that violence against women in all its forms is widely prevalent throughout and that it is a gross violation of women's human rights;

**Recognising** that it has serious adverse consequences on the physical, mental and reproductive health of women and can also have serious effects on the health of their infants and children (particularly when they are also victims or in the case of children witnesses);

**Recognising** the need for developing special expertise and specialised care for meeting the needs of women who suffer violence; and

**Recalling** the 1993 UN Declaration on Violence against Women and the Platform for Action of the Fourth World Conference on Women;

**Supporting** the Recommendations reached by the FIGO Committee for the Study of Ethical Aspects of Human Reproduction.

### **1. Invites Member Societies to:**

- Urge their governments to implement the recommendations made by the Beijing Platform for Action and to ratify the Convention on the Elimination of All Forms of Discrimination Against Women if they have not already done so, and to ensure its implementation if they have already ratified it. Urge their governments to take legal and other measures needed to make violence against women unacceptable to all groups in society.

- Ensure that violence against women is included in the curricula of all reproductive health care providers, in the specialist training of obstetricians – gynaecologists and in programmes for continuing education and that the health system does not in any way contribute to the victimisation of women.

- Collaborate with national authorities, non-governmental and intergovernmental organisations and the media to promote and support measures to prevent and address the consequences of violence against women, and to communicate with the appropriate bodies to provide an effective safety net for women suffering from violence.

### **2. Recommends that obstetricians and gynaecologists:**

- Educate themselves, other health professionals and community workers about the extent, types, and negative consequences of violence against women.

- Increase their ability to identify women who are experiencing violence and to provide supportive counselling and appropriate treatment and referral.

- Work with others to better the understanding of the problem by documenting the determinants of violence against women and its harmful consequences.

- Assist in the legal prosecution of cases of sexual abuse and rape by careful and sensitive documentation of the evidence.

- Support those who are working to end violence against women in their families and in communities

Approved by the FIGO General Assembly at the XV FIGO World Congress of Gynecology and Obstetrics, Copenhagen, Denmark, 3-8 August 1997.

Available online at: [http://www.figo.org/initiatives\\_violence\\_against\\_women.asp](http://www.figo.org/initiatives_violence_against_women.asp)

# CODES OF ETHICS AND DECLARATIONS RELEVANT TO THE HEALTH PROFESSIONS

Health professionals have been active in the work of Amnesty International since its inception, and have played an increasingly valuable role in documenting human rights abuses, arranging treatment for victims, and campaigning for the observance and the strengthening of human rights and ethical standards. In this newly revised and expanded edition, *Codes of Ethics* illustrates the critical milestones and technical instruments developed during recent years. It presents an invaluable reference tool for all professionals engaged in medical ethics to inform effective human rights advocacy.



**AMNESTY**  
INTERNATIONAL



[www.amnesty.org](http://www.amnesty.org)