EDITORIAL

A Guided Tour through Key Principles and Issues of the Human Rights-based Framework as Applied to Health

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Abstract

The paper starts with a tour de force that sets the parameters of the human rights framework for the neophyte to this topic. The human rights-based framework allows us to actively challenge the prevailing marginalization of the poor in society with all their preventable ill-health, malnutrition and deaths. The "invisible hand" of the market has simply no capacity to create a decent human rights-based society for all. There has been much circularity in the discussion of the right to health; now, more concrete actions need to be taken. How much of their budgets governments devote to health services and to poverty alleviation is of substantive human rights concern. Now is the time to convert these concepts into working programs and into people's empowerment for them to claim their right to health, i.e., our work has to yet acquire a more operational human rights meaning so as to empower the people we purport to serve. The challenge is a political one - and that is what this paper explores.

I. A tour de force to set the stage for neophytes: Why we live in a new age of rights

1. At the beginning of the 21st century, the implementation of the articles of international law (those laws that sanction the human rights principles as enshrined in the different United Nations Human Rights Covenants) represents the right political approach to development in the area of health, particularly because it allows us to actively challenge the prevailing and often growing marginalization, as it also allows us to tackle the preventable ill-health of poor and powerless people in society.

2. The human rights framework has received increasing recognition as the emerging paradigm in international development discourse. This is because it is considered a long overdue return to the spirit and letter of the UN Charter (1946) and of the Universal Declaration of Human Rights (1948). In his 1997 Reform Proposal, the Secretary General of the UN called for all UN agencies to mainstream human rights in all their activities. This is now the prevailing mandate for them…and that makes the timing right for us to now forcefully step into the implementation of the "health as a human right" paradigm being characterized in this article.

3. To put things in a historical perspective, over the last two to three decades (how we got to where we are), in the Basic Human Needs Approach, beneficiaries have no active claim to their needs being met. The "value-added" flowing from the new Human Rights-based Framework is the legitimization of such claims giving them a politico-legal thrust.

4. The Human Rights paradigm thus importantly contrasts with the Basic Human Needs approach in the ways depicted in the box below. The box highlights some of the key elements of the transition towards the human rights-based framework that the reader should be aware of.

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The shift from the Basic Needs Approach to the Human Rights-based Approach has meant a change in language and in the focus; the same reflect the clear shift in the emphasis of the new paradigm. Here are the major differences:

Basic Needs Approach	***Human Rights-based Approach***
Needs are met or satisfied.	Rights are realized (respected, protected, facilitated and fulfilled).
Needs do not imply duties or obligations, although they may generate promises.	Rights always imply correlative duties or obligations.
Needs are not necessarily universal.	Human rights (HR) are always universal.
Basic needs can be met by goal or outcome strategies.	HR can be only realized by attention being paid to both outcome and process
Needs can be ranked in a hierarchy of priorities.	HR are indivisible, because they are interdependent; there is no such thing as "basic rights"
Needs can be met through charity and benevolence.	Charity and benevolence do not reflect duty or obligation, and are not in the vocabulary of human rights.
It is gratifying to state that "80% of all children have had their needs met by having been vaccinated".	In the human rights framework, this means that 20% of all children have not had their right to be vaccinated realized.
In an example coming from nutrition we would say: The government does not yet have the political will to enforce legislation to fulfill the basic need to iodize salt.	*In human rights terms we say: The government has chosen to ignore its duty by failing to enforce legislation to iodize all salt. (U. Jonsson 2003)*

5. The bottom line is that there is a big difference between people having basic needs and having universal rights: the latter can be legitimately claimed and are even what is called justiciable which means human rights violations can be brought to court - even if it is against the government.

6. In the basic needs approach, the individual is seen as an object with needs (and needs do not necessarily imply correlative duties or obligations, but promises). In the rights-based framework, the individual is seen as a subject with legitimate entitlements and claims (and rights always imply and are associated with correlative duties and obligations). Therein lies the big difference.

7. In the era of globalization, the human rights paradigm is, right now, trying to impose itself over the ruling, neoliberal paradigm of development. This clearly represent the way forward for all of us, because HR works with claim holders for them to demand their rights and with duty bearers to live up to their obligations as sanctioned by international law. Keep in mind that countries voluntarily ratified the several UN Human Rights Covenants. See End-note No. 1 below for a list of these covenants.

8. The main challenges faced by this new HR framework are (a) for progressively more people working in development, and in our case health, to become familiar with its principles and standards; (b) to have practitioners apply the new framework (to make it operational) so as to replace the obsolete current paradigm. Hence this guided tour to give you some of the tools to address these challenges with a HR perspective.

9. What also needs to be done, in our case soonest, is (a) to propose and start implementing accepted rights-based processes that will lead us to measurable outcomes of greater respect of people's health rights, (b) to start using those processes to progressively organize claim holders and duty bearers, (c) to lobby governments to adopt and enforce the means to accomplish the progressive realization of the right to health, and (d) to monitor progress towards its achievement. (C. Schuftan, 2006)

10. The major players in this contemporary debate can be found in UN agencies, NGOs, academia, labor unions, women's organizations, political parties and other civil society organizations. In short, the debate is permeating the whole development scene. This is why we think you need to educate yourself more on the human rights framework.

11. For the reminder of this paper, we will contextualize the human rights-based framework as it relate to the right to health.

II. Why does our commitment to the human rights-based framework to work in health need to grow?

12. I would argue that our commitment is needed, among other reasons (but not only), as a reaction to the additive negative impacts of Globalization that we just cannot ignore any longer. Globalization is in good measure behind the acceleration we see in poverty levels, in preventable deaths, in disparity, in exclusion, in unemployment, in marginalization, in alienation, in environmental degradation, in exploitation, in corruption, in violence and in ethnic/religious conflicts. The invisible hand of the global market has simply no capacity to create a decent human rights-based society for all.

13. During this process of relentless capitalist accumulation, serious social cleavages have eventually occurred. One would think these would have sobered us. But we are now living in yet another utopia, one that extols the ultimate benefit of Globalization. This utopia is based on the dangerous mythical belief that ultimately the free market will make everybody happy and healthy. (S. George, 1999)

14. Because the rights-based framework takes the legitimate entitlements of those being marginalized as its starting point, a preliminary consensus needs to be reached that Health For All, to be sustainable, must be based on equity. (FIAN 1998)

15. The reasoning behind the HR framework is that adding the accountability factor (that all human rights bring with them) into our work is our best reaction to the increasing inequities being brought about by Globalization. Accountability was already a central feature of the UN Charter - but be the judge of how much it was heeded since 1946.

16. Since the Secretary General's speech in 1997, there has been much circularity in the discussion of human rights, especially as it applies to health. Now, more concrete actions need to be identified. There is still a segment of the human rights community that thinks that one can settle world order issues without addressing the power issues that still work against the majority of the marginalized and the vulnerable. One can safely conclude that worldwide development will simply not take place through the benevolence of the Global Free Market and of those who, through their power, control it.

17. To sum up, the human rights framework is here to set limits to the vicissitudes and sways of the (socially insensitive) market.

III. The Challenge: What changes? (or What does the new human rights framework bring to the struggle for health of the poor?)

18. Because of the fatal flaws of Globalization as the latest stage of Capitalist development, a more people-centered local governance is now, more than ever, needed.

19. It is a fallacy to focus on whether Globalization *or* bad governments are the most important cause of violations of the right to health. The human rights framework shows us what states should-do or not-do. When they fail the test, many governments actually use the Globalization argument (of being 'victims of the global process') as an excuse for not implementing their obligations. [Keep in mind here that the duty to fulfill the right to health does not depend on an economic justification and does not disappear because governments can show that tackling some other problems is more cost-effective].

20. Most often, a rights-based framework to health is not even on governments' 'radar screens'. The United States, for example, has regarded the socio-economic rights of the Universal Declaration of Human Rights as a wishful "letter to Santa Claus" (Jean Kirkpatrick, former US ambassador to the UN). The US has little sympathy for Social, Economic and Cultural Rights, in contrast to its vociferous and selective support of Civil and Political Rights.

21. In the case of all governments, how much of their general budgets they devote to health, to food, to education and to poverty alleviation has substantive human rights implications. One should thus look at how the various expenditures are distributed among the various population groups. Governments do violate human rights when they fail to offer adequate health services to certain segments of society.

22. A human rights-focused analysis of statistical data should examine the extent to which various expenditures in social and other services are distributed among the diverse population groups according to need. Beneficiaries' watchdog groups have to scrutinize these actions to make sure they 'respect, protect and fulfill' human rights - and actively protest if they fail to do so. [In all candor, the very way in which statistics are now organized and presented in a non-disaggregated way by government agencies may already be one of such violations].

23. So, this is the theory. But what we have real problems with right now is to convert these concepts into working programs and people forcefully claiming for their health rights, so as to implement a rights-based, health care delivery model covering all the needed components of the rights-based framework. (C. Schuftan, 2005)

24. Here, the first challenge will be to create a common language with governments and NGOs, a language primarily based on social commitments to the right to health. The second challenge will be to make the human rights-based framework concrete and give it substance, i.e., we desperately need more concrete rights-based health programming approaches. (U. Jonsson, 2003)

25. But for now, most governments fear that the recognition of the right to health will interfere with their policy choices. They will have to be made to understand that, for instance, certain aspects of the right to health may be subject to progressive (gradual) realization. On the other hand, poorer states will have fewer resources available. But there is a minimum core of health rights that they all have to uphold! States have to guarantee the respect of those rights under any circumstance, irrespective of the resources available to them.

26. What this means is that, progressively, right to health objectives need to be better defined and refined to more explicitly match Universal Human Rights goals. [Human rights have yet to acquire a more operational meaning for people, and that is a major political responsibility we all have to deal with now. Or, put another way, in operational terms, effectively mainstreaming human rights in all development activities remains a challenge of enormous dimensions - and the challenge is a political one]. (C. Schuftan, 2003)

27. The main challenge here is to achieve consensus among health workers on such an operationalization - and that is unthinkable out-side an ideological framework which inevitably brings us back to the left/right, capitalism/social-

ism divide of "to all according to their needs regardless of their means".

28. What will become central in this debate is for all of us to understand that human rights means the right to demand a whole series of things. Among them:

- that economic and physical access to basic services is equally guaranteed, especially for girls, women, the elderly, minorities and the marginalized,
- that, since all rights are created equal, steps be taken to progressively achieve *all* human rights,
- that expeditious and verifiable actions be undertaken towards realizing those rights,
- that accountability, compliance and institutional responsibility be required in all processes,
- that unwillingness be differentiated from inability (lack of capacity) to comply,
- that states prove that there are reasons beyond their control to fulfill their obligations,
- that the private business sector (national and transnational) also complies with human rights dispositions,
- that national strategies on human rights - and the right to health - be adopted that define clear benchmarks and objectively verifiable indicators of progress,
- that the implementation of national strategies is transparent, decentralized, insists on people's participation and moves towards eliminating poverty, ill-health and malnutrition,
- that new legislation be developed involving civil society representation in its preparation, its enforcement and its monitoring.

29. If the above demands are met, the added value/advantages of the rights-based framework will accrue in a way that:

- beneficiaries become active claimants (i.e., actively demand their rights),
- the process underlines the (international and national) legal human rights obligations of states,
- Universal Human Rights provide the principled framework used to make decisions,
- the respective human rights imperatives can be made more forcefully (making governments effectively liable).
- the process moves the debate from (the flawed approach of) charity/compassion (where there is already fatigue) to the language of rights and duties (accountable to the international community with compliance that can be monitored). [Keep in mind that, as opposed to rights, charity is given mostly when convenient]. (U. Jonsson, 1997)

30. Furthermore, a set of what I call 'iron laws' differentiate this new approach from the prevailing one in no uncertain terms as is depicted in the box on page 73.

31. The question we are left with when collectively looking at the iron laws in the following box is: Will our adoption of the new right to health framework be any more capable of solving pending fundamental health issues (including its social determinants)? This question is pertinent at this point since it is the *same* fundamental issues which have been and are the central constraints that have limited progress and sustainability in prior development efforts. We are talking about the political constraints.

IV. The politics of it all

32. Politics is nothing more than the ability to resolve, time and again, conflicts of interest. (S. George, 1999)

33. Human rights ultimately give direction and boundaries to contemporary political and economic choices; some economic choices simply are not permissible, even if they promise a good return (e.g., slavery). Just like the limits of a national Constitution, there are things politicians can simply not do, and other things they have to do. That is how we should conceptualize human rights. (U. Jonsson, 1997)

34. I thus see our adoption of the human rights framework in health as the beginning of a political movement; one that aims to develop and implement a non-ethnocentric global, egalitarian

The Human Rights-based Framework: Some Iron Laws:

As the new era of human rights-based planning and programming in development work gets under way, there are a number of iron laws that begin to gain acceptance. Among them, and in no particular order, I would say, are the following:

- The struggle for human rights is more than a struggle to defend legitimate immediate interests, but is a struggle for universal justice.
- Human rights are inseparable from social justice. But to be effective, they require the adoption of appropriate policies and legislation at national and international level.
- A right is a right only when it is universal; otherwise it is a privilege.
- Human rights have already been accepted by almost all countries as universal, indivisible principles. No further discussions are necessary. The burden of compliance is now on the world's signatory state parties.
- Human rights are obligatory, not optional for states. They require governments to undertake active and effective steps in this direction.
- The human rights framework places development work within an internationally recognized *and* legally binding normative framework (a significant foundation that is currently absent from prevailing development approaches and activities).
- Rights can be usefully seen as the codification of needs, reformulating them as ethic-legal norms and thus implying a duty on the part of those in power.
- All unmet basic needs, including those in health and nutrition, represent violations of rights.
- Up until a specific right is realized, this right is to be considered violated.
- Society produces endless 'justifications' for human rights violations which are often even accepted by the oppressed themselves. Human rights work debunks these justifications. It liberates minds and mobilizes people.
- The ongoing feminization of poverty is a violation of Women's Rights. The time has come to call these realities what they truly are: Human rights violations. New human rights legislation has, therefore, to incorporate a gender perspective.
- The notions of duty and justice (and not merely social responsibility or compassion!) give rights their cutting edge.
- A lack of human rights means multiple denials. Therefore, poverty is the main obstacle to the attainment of human rights and the right to health.
- The health sector and other social sectors are often left to deal with the results (the consequences!) of existing human rights violations.
- One strategy can often be used to address the violation of several different rights.
- Human rights facilitate the building of alliances - the joining of hands with millions of others - since appeals for justice generate worldwide support for widely shared moral reasons.
- Power is the key relation in human rights. A right confers power, i.e. the power to change some normative relations long taken as given - provided the system makes it possible for claim holders to do so. (…and we have to help making this possible).
- In sum, Montesquieu had it right: It is necessary from the very nature of things that power should be a check to power. (SCN, 1999; U. Jonsson, 1997 and 2003).

human rights-based ethics and praxis in our daily work.

35. In the real world, there is a need for a political solution to our major human rights concerns. In the last instance, only politics will determine the speed with which the ultimate achievement of human rights will be realized.

36. On the other hand, political leaders *do* understand that change is more inevitable when communities forcefully demand what they have the right to. Now, as health workers, we need to more forcefully work with these communities for them to actively claim their rights.

37. Human rights language aims at raising social commitments. It is a very politically powerful language. As our social commitment increases, our level of political responsibility also increases.

38. The question, of course, here, is: Are we all likely to have the strength and the political will to use human rights effectively as our new weapon against global violations of the right to health? Or put otherwise, will the explicit inclusion of human rights into the politics of the prevention of ill-health and malnutrition make any difference to the many millions whose lives are blighted by these problems?

39. One can be skeptical though. Not much has really changed so far. This is primarily because of the political sensitivities resisting the solution of these issues. But these sensitivities are now under siege: We are at a point where you cannot but take sides! Get prepared for a fair struggle.

V. The participation factor

40. Is fostering a viable and militant civil society a key to pressure governments into doing what they are supposed to do in the first place after having solemnly signed all those international human rights covenants?

41. If yes, then traditional capacity building alone is not going to be enough. We need to empower the members of civil society organizations to be effective in working with people for their rights to be ultimately upheld. To succeed in this, we need to foster citizens action in a broad two-way consultative process aimed at enforcing their right to health. The human rights framework also forces institutions to take sides: and they are not always well prepared to do so.

VI. The use of the right indicators

42. Tools need to be developed to assess the impact of (or progress in) work in health when using a human rights-based framework. Under the new right to health paradigm, activists in every country must demand objectively verifiable indicators and benchmarks be set to monitor the evolving health status of primarily up-to-now marginalized people.

43. Activists also need to reanalyze all the information stored in official data banks of routine data collection systems to try to reinterpret that information from a human rights perspective, i.e., disaggregating it by gender, socio-economic and ethnic group and other pertinent parameters that can uncover flagrant or hidden inequities and right to health violations. (SCN, 1999)

VII. Human Rights from the United Nations' and the NGOs' perspective

44. UN agencies are considered to be duty bearers particularly in terms of compiling, publishing and monitoring indicators of human rights worldwide. It is also the UN agencies' role to hold states accountable for non-compliance with their specific human rights obligations; in such a function, they act as political mediators. However WHO has not done much of the latter so far.

45. Moreover, since the respective Human Rights Covenants already delineate both state *and* societal obligations, many think civil society, NGOs, the private sector and others in the national and international community can also be considered bona-fide duty bearers.

46. The role of civil society groups is to, among other, act as pressure groups. Therefore, to guarantee gains, civil society will have to continue its strong political mobilization effort in a bid to

hold national and international institutions with obligations in the realization of, in our case, the right to health accountable.

47. This, because overseas development cooperation (ODA) does not automatically contribute to the respect of the right to health. Civil society will thus have to oppose health projects that are ill conceived and even counterproductive in right to health terms. Ergo, development agencies will need to fix their sights more on the right to health dimension of their work and civil society will have to create and sustain the pressure for this to happen.

48. The NGO community can indeed play a major role in this. Among other things, they will have to:

- keep asking the right questions that seek information on violations/fulfillment of the right to health,
- submit written statements (plus photo and video documentation when appropriate) to authorities and to watchdog groups on their assessments and findings,
- follow up on corrective measures taken (or not taken),
- detect bad faith in the implementation of right to health obligations, and publicly denounce this fact if found.

49. The caveat here is that organizations can use (and get away with using) human rights language as non-committal rhetoric just to feel good and 'move with the tide'.

50. Finally, we still need to clarify the role of the for-profit private sector in the right to health discourse. Historically, small local enterprises have, in general, not been a big threat to the right to health; Transnational Corporations, especially pharmaceutical houses, *have*. Now *they* need to be held accountable. Little has been written on this topic so far. Some breakthrough will be needed here. I declare my incompetence on this issue.

VIII. Writing Human Rights into law

51. In all honesty, many governments (if not most) continue to take a soft approach to the implementation of the right to health. Human rights actually require a people-oriented state - a fact that superficially may seem obvious, but of course is not.

52. There are at least two challenges in this front to which they are not living up to. On the one hand, they need to adopt corrective legislation and take administrative measures to amend and abolish dispositions that are now contrary to human rights in general and the right to health in particular. On the other hand, new needed legislation needs to be put in place.

53. The new national legislation will have to contain specific benchmarks and corresponding time frames which can be monitored.

54. Because of the acute current monitoring needs, it is important to establish National Human Rights Commissions whose funding is independent of government. When laws are then promulgated, states will simply have to respect the work of these human rights advocates and other watchdog groups - including the work of non-nationals involved in taking steps to foster the respect of human rights; there should be no fear of harassment or persecution for them.

55. Very early drafts of proposed legislation must be forwarded to civil society movements, labor unions, academic and scientific associations, private sector representatives, relevant government bodies and international organizations for review.

56. Later on, a powerful measure that could be implemented is for victims of right to health violations to be entitled to adequate reparation. For this, one could conceive of nationally respected ombudsmen or national Human Rights Commissions being put in charge of holding hearings for victims of such violations.

57. In their periodic required reporting on human rights to the UN, Party States have to acknowledge: implementation problems, existing relevant national legislation and rules, regularity of monitoring (open to public scrutiny), priorities established and how the administration makes sure the right to health has been implemented, how

progress is being evaluated and the specific measures taken to achieve the realization of this and other rights. The UN has already written this in into current state obligations. Civil society now just has to sign-off on these reports to keep them truthful.

58. In sum here, we should agree that without enshrining economic, social and cultural rights into explicit legislation, there is no guarantee that these rights can be made effective. The absence of powers to make governments accountable and responsible to their citizen on these fundamental rights is one of the greatest obstacles to rights-based agendas.

IX, Training in Human Rights

59. Having a human rights framework does not automatically change the way health managers think about current violations of the right to health. Only through a long process of incorporation of these politico-legal and other principles into everyday norms and directives *and* into service training programs will it be possible to progressively change deeply rooted human rights-neutral or human rights-opposed attitudes.

60. Right to health standards have thus to be incorporated into personnel training, because by using these standards they will gain an additional degree of authority and power, at the same time becoming more accountable. (UNICEF ESARO, 2005)

X. Some conclusions

61. Betting on the invisible hand and ignoring the health rights of the socially excluded is immoral; it is the issue of a deliberate collective social exclusion that we are out to combat.

62. Borrowing a term from sub-comandante Marcos of Chiapas fame, the first challenge we face in right to health work is to bring the human rights issues to a level of "impertinent consciousness" where it bothers us *not* to get involved.

63. Are we here taking for granted that people everywhere know what their health rights are and how they should be realized? No. Do people even agree that applying a human rights-based framework is a priority? No. Is this paper thus condoning a top-down approach to social development by vigorously promoting this new approach? No again. The political agenda to accept this approach is not yet set. Does this put us at a great disadvantage? No. We are clearly inching towards such an agenda. (We hope to count you, the reader, among the new proponents).

64. In the strategy of imposing the new right to health paradigm over the old and obsolete development paradigm (paradigms do not change progressively; a break always occurs when the old one does not provide the answers to existing problems or questions), we have to get involved in a long haul capacity building, advocacy, social mobilization and people's empowerment effort so as to influence short, medium and long term health outcomes.

65. To succeed in this, we need to change current realities in a socially and politically relevant manner; our actions will thus have to be based on a strong political discourse.

66. Normatively, this means we need to go from declarations (UN Declaration of Human Rights, Convention of the Rights of the Child, Convention on Eliminating Discrimination Against Women) to national plans of action, and to national legislation on these rights.

67. Operationally, it means we actually need to go from people articulating their health and nutrition needs into launching specific claims aimed at specific duty bearers who already have clearly delineated obligations. These claims have to then become enshrined in laws that are enforceable in practice; in the enforcing of these laws, we need to join hands with all strategic allies working on the protection of other human rights to tackle all possible obstacles and effectively neutralize all strategic enemies.

68. We all know that it is easier to fight for one's principles than to live up to them.

At every step of the fight you-commit-yourself-to-embark-on, just keep in mind that the actual individual issues you will be fighting for, together with the beneficiaries you work for, are important, but not crucial: The process is! More impact does not require just more inputs. It is not about doing the things right; it is about doing the right things and accessing the right leverage points that will make the big difference.

69. The human rights framework thus brings to the forefront the point many of us health activists have been making for over 30 years. Previous development initiatives had good intentions in them; we could have gone further with the Basic Human Needs Approach or with Primary Health Care. But we did not. Basically, because the political resolve to tackle the structural determinants was not there (or was not widespread enough).

70. A lot will have to be deconstructed before we can start to set up the new right to health framework. What in this process may look destructive from outside is actually a necessary precondition. Resolving the principal contra-dictions in each country will require identifying the main opponents of the new approach, as well as the right tactics and strategies to forward the noble cause of human rights in general and the right to health in particular.

End-note: Core UN treaties:

United Nations Charter, 1946.

Universal Declaration of HR, 1948 (does not require ratification)

International Covenant on Civil and Political Rights, 1966 (Ratified by 149 states). Has 2 optional protocols; monitored by the new UN HR Council.

International Covenant on Economic, Social and Cultural Rights, 1966 (Ratified by 147 states); monitored by the Committee on Economic, Social and Cultural Rights.

International Convention on the Elimination of All Forms of Racial Discrimination, 1963 (Ratified by 168 states); monitored y the Committee on the Elimination of Racial Discrimination.

Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (Ratified by 173 states); one optional protocol; monitored b the Committee on the Elimination of Discrimination against Women.

Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Ratified by 133 states); monitored by the Committee Against Torture.

Convention on the Rights of the Child, 1989 (Ratified by 192 states); two optional protocols; monitored by he Committee on the Rights of the Child.

Convention on the Rights of Migrant Workers, 1990.

Convention on the Rights of Persons with Disabilities, 2006

To date, 80% of states have ratified at least four of the seven major HR conventions; all countries have ratified at least one of them.

We emphasize that States have become parties to the international HR instruments above on a voluntary basis, and thereby obligate themselves to comply and to report periodically to the existing independent monitoring bodies on their implementation.

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