

Right to Health

The Application of International Laws in
the Islamic Republic of Iran

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Lay-out and printing by Optima Grafische Communicatie
ISBN 978-94-6361-235-7

**Right to Health;
the Application of International Laws in
the Islamic Republic of Iran**

Recht op gezondheid;
de Toepassing van Internationaal Recht in
de Islamitische Republiek van Iran

Thesis

to obtain the degree of Doctor from the
Erasmus University Rotterdam
by command of the
rector magnificus

Prof.dr. R.C.M.E. Engels

and in accordance with the decision of the Doctorate Board.
The public defence shall be held on

6th June 2019 at 9:30

by

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LIST OF ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability, Quality
ACHPR	African Commission on Human and Peoples Rights
Art.	Article
CC	Constitutional Court of South Africa
CEDAW	UN Convention on the Elimination of all forms of Discrimination against Women
CERD	UN Committee on the Elimination of Racial Discrimination
CESCR	UN Committee on Economic, Social and Cultural Rights
COE	Council of Europe
CPRs	Civil and Political Rights
CRC	UN Convention on the Rights of the Child
CRPD	UN Convention on the Rights of Persons with Disabilities
Doc.	Document
E3	Germany, France and Italy
ECSR	European Committee of Social Rights
ECtHR	European Court of Human Rights
ESCRs	Economic, Social and Cultural Rights
EU	European Union
FAO	Food and Drug Organization
FGM	Female Genital Mutilation
FP	Family Planning
GC	General Comment
GDP	Gross Domestic Product
HeRWAI	Health Rights of Women Assessment Instrument
HRC	UN Human Rights Council
HRIA	Human Rights Impact Assessment
Inter-Am.C.H.R.	Inter-American Commission on Human Rights
IAEA	International Atomic Energy Agency
ICCPR	UN International Covenant on Civil and Political Rights
ICERD	UN International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	UN International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
ILO	International Labour Organization
MDGs	Millennium Development Goals

MOHME	Ministry of Health and Medical Education of Iran
NCD	Non-communicable Disease
NGO	Non-Governmental Organization
OECD	Organization for Economic Co-operation and Development
OHCHR	Office of United Nations High Commissioner for Human Rights
OP	Optional Protocol
PHC	Primary Healthcare
PPP	Purchasing Power Parity
REC	Recommendation
RES	Resolution
SC	Supreme Court
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCHR	United Nations Commission on Human Rights
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner of Human Rights
UNICEF	United Nations Children's Emergency Fund
UNHCR	UN Refugee Agency
UNTS	United Nations Treaty Series
WHA	World Health Assembly
WHO	World Health Organization
WMA	World Medical Association

PART I

INTRODUCTION

Chapter 1

General Introduction and Research Framework



1.1 BACKGROUND AND STATEMENT OF THE PROBLEM

In recent years, the right to health has played a prominent role in international, regional and national human rights laws and policies. Medical care is an important component of the right of everyone to an adequate standard of living which is recognised by the Universal Declaration of Human Rights (1948).¹ However, sixty-nine years after the adoption of this Declaration, based on recent figures, approximately two billion people still do not have access to primary healthcare. Millions are suffering from illnesses that are either preventable or treatable with existing medicines. Moreover, due to a lack of access to primary healthcare, many children die or grow up stunted in the developing world.² These facts indicate that the realization of the right to the highest attainable standard of physical and mental health (hereafter, right to health) has not been achieved in many areas of the world. According to the International Covenant on Economic, Social and Cultural Rights (ICESCR), states are required to realise this right progressively.³

In 2004, the High Commissioner for Human Rights announced that the achievement of the right to health is the most important worldwide social goal. This goal is a distant one for millions of people throughout the world, particularly for the poor; for them, this goal is even becoming increasingly remote.⁴ Currently, while people are demanding that their rights be respected, protected and fulfilled, governments are struggling to strike a balance between their human rights obligations and available resources. Today more than ever before, the question of how the right to health can be fully realized is receiving attention. Advancements in the realization of the right to health depend upon both national provisions and how international standards are applied in a particular national context.⁵ Human rights treaties constitute standards that should be applied within the domestic systems of countries and a set of norms for the conduct of both states and non-state actors with respect to the rights. States should adopt national health strategies and plans of action for the realization of the right to health and should establish national mechanisms to monitor their progress. Realization of the right to health should be progressive; that is, factors affecting

1 Universal Declaration of Human Rights 1948, art 25

2 World Health Organization (WHO), *World Medicines Situation* (WHO 2004) 61

3 International Covenant on Economic, Social and Cultural Rights 1966, art 12

4 Office of the UN High Commissioner for Human Rights, *Resolution 2004/27: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2004) para 2

5 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 9 ICESCR: The Domestic Application of Covenant on Economic, Social and Cultural Rights* (1998) para 4

negatively fulfilment of the obligations should be identified, and people's enjoyment of their rights should be improved.⁶

Once a state ratifies an international human rights treaty, its compliance with the provisions of the treaty should be assessed and monitored. States are required to submit periodic reports related to the realization of economic, social and cultural rights (ESCRs) to the Committee on Economic, Social and Cultural Rights (CESCR). Based on these reports, the Committee provides Concluding Observations that address shortcomings and contain recommendations for the better realization of the rights in a given country. This report-based monitoring system provides a great deal of qualitative information for improving the realization of rights; however, the reports are of poor quality and often outdated. Moreover, they are not easily analysable or comparable over time. Because of the limited duration of monitoring sessions, it is not possible to review the reports in detail.⁷ In addition, states consider this monitoring system as a part of the international accountability process rather than as a tool for detecting problems and promoting national solutions.⁸ Therefore, to understand the level of realization of the right to health, country reports are not sufficient. They should be supplemented with assessment studies using human rights impact assessment tools. These types of studies can increase awareness of problems related to the equal enjoyment and exercise of rights. They help to identify the causes of the problems and might generate political commitment to take action in order to improve the realisation of the rights.⁹

In this study, the conduct of the Islamic Republic of Iran (hereafter, Iran) in the realization of the right to health is assessed. Iran is the 16th largest country in the world, with an area of 1.648.000 square kilometres. It is a middle-income country located in the Middle East. According to the 2016 census, the population of Iran was 79.926.270, and the annual population growth rate was 1.24%. Approximately 30% of Iran's population is younger than 30, and 6.5% of the population is older than 65.¹⁰ According to the World Health Organization (WHO), life expectancy at birth for men and women was 74 and 77 years, respectively, in 2015. Iran's total

6 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 14 ICESCR: The Right to the Highest Attainable Standard of Health* (2000) paras 53-55

7 Heymann J. McNeill, K. Raub, A. 'Assessing Compliance with the Convention on the Rights of the Child Indicators of Law and Policy in 191 Countries' [2014] *International Journal of Children's Rights* 22 (3) 425-445

8 United Nations Children's Fund (UNICEF) Innocenti Research Centre, *the General Measures of the Convention on the Rights of the Child the Process in Europe and Central Asia, For Every Child Health, Education, Equality, Protection, Advance Humanity* (UNICEF 2006) 35

9 Ibid

10 Statistical Centre of Iran, 'Population Statistics 2017' (Statistical Centre of Iran, 2017) <<https://www.amar.org.ir>> accessed 12 May 2017

expenditure on health was 6.9% of the Gross Domestic Product (GDP) in 2014.¹¹ In addition to recognition of the rights to health and social security in its Constitution, Iran has several laws and policies on health and the right to health. This country has a countrywide health services network that has had a respectable outcome related to improving the health situation of Iranians in recent years. Through expansion of the health insurance system and a significant reduction in patients' share of healthcare expenditure, Iran has improved affordability of health services. However, long boundaries with countries in conflict, international isolation, war, and international economic sanctions have significantly affected the welfare of Iran's population.¹²

Iran ratified the ICESCR in 1975 and committed to the Covenant's obligations with no reservations. Iran has a constitutional provision stipulating to the applicability of international treaties in national law.¹³ Few studies have addressed the situation of the right to health in Iran's laws and practice. In order to increase awareness about the situation of the right to health, and probable gaps and inequalities in people's enjoyment of this right, and to provide recommendations for the better realization of this right in Iran more studies are needed.

1.2 RESEARCH OBJECTIVES, QUESTIONS AND OUTLINE

This research is based on an analysis of the legal framework of the right to health in Iran and the country's conduct in realization of this right. Ratifying human rights treaties creates both entitlements for the country's population and binding obligations on states. The aim of this study is to gain insight into national health laws and the actual access of people to health facilities, services and products to ascertain the strengths and weaknesses of Iran in guaranteeing the right to health. It also includes identifying gaps and barriers in providing equal access to everyone. Based on these findings, recommendations for improving national laws and policies in order to enhance the enjoyment of the population of the right to health can be provided. Iran has been chosen for this case study for five reasons. First, this country is a developing country that, similar to other developing countries, is seeking to become more socially and economically advanced. The transition process can have a direct effect on the realization of the rights of population.¹⁴ Second, this country has been

11 World Health Organisation (WHO), 'Statistics of Iran 2017' (WHO 2017) <<http://www.who.int/countries/iran/en/>>accessed 12 May 2017

12 United Nations Children's Fund (UNICEF), *Annual Report for Iran 2012 (MENA)* (UNICEF, 2012) 1

13 Iran's Constitution 1979, art 77

14 Horowitz, Sh. Schnabel, A. *Human Rights and Societies in Transition; Causes, Consequences, Responses* (United Nations University Press 2004)13

targeted by comprehensive international economic sanctions, resulting in less access to resources for realization of the rights. Third, Iran is an Islamic country that shares values and traditions with other Islamic countries which in some cases such as equality of men and women in their rights are in contrast with international standards of human rights. Four, Iran is located in the Middle East, which is one of the world's most conflict-prone regions and its political leaders frequently have been critical of Western models of political liberalism.¹⁵ Finally, Iran has frequently claimed that the reports of the UN Special Rapporteurs and experts on the situation of human rights in this country were not reliable because they showed the situation to be worse than it actually was.¹⁶ These all make Iran a special country for studying human rights. The results can be helpful for realising the right to health in countries with similar conditions, for example developing countries, countries under the pressure of economic sanctions, countries in the Middle East and Islamic countries.

The main questions of the study are first, whether the national laws and policies of Iran are compatible with international human rights laws related to health and second, whether the current means of protecting the right to health are sufficient in this country (based on human rights impact assessment frameworks). This study is divided into several chapters that address the following research questions.

- According to international health and human rights laws, what is the right to health and what are the related obligations of states?

To assess whether the conduct of a country is sufficient to realize the right to health, there is a need to identify the subjects of the assessment; health, right to health and obligations of the country. The WHO has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁷ The definition provided by the ICESCR for the right to health is “the right to the highest attainable standard of physical and mental health”.¹⁸ This definition requires clarification because it does not show exactly that to which people are entitled based on the right to health nor what the resulting obligations of states are. The purpose of chapter 2 is to review the formulation of the right to health in human rights treaties in order to contribute to an improved implementation of this right in Iran. After providing a review of human rights in general, various aspects of the right to health and states' obligations concerning this right are explained.

15 Forsy, P. D. *Human Rights in International Relations* (2ndedn, Cambridge University Press, 2006) 148-149

16 Iranian Foreign Ministry Spokesman, 'UN human rights reports on Iran are unreliable' (IRIBNEWS 2018) <<http://www.iribnews.ir/fa/news/2047405>> accessed 25 August 2018

17 Constitution of the World Health Organization 1948, Preamble

18 International Covenant on Economic, Social and Cultural Rights, supra note 3, art 12

A very important issue that might affect complete realization of the right to health is justiciability. It influences the views of governments concerning their obligations with respect to this right; a justiciable right is more likely to be recognized. Without judicial support, provisions related to such a right might not be considered as legal obligations. The answers to the questions of whether this right can be enforced by judicial authorities, and whether a country failing to undertake its obligations related to the right to health should be accountable to international and national authorities depend upon whether this right is justiciable. Chapter 3 addresses the justiciability of the right to health in the international human rights legal system. (The results of this part of the study was published in the Iranian Journal of Medical Law in 2016.)¹⁹

- Are the current means for the protection of the right to health sufficient in Iran?

International laws on the right to health have established standards that should be incorporated into national laws. Chapters 4, 5 and 6 aim to investigate, with respect to both these laws (which are applicable to Iran) and national laws, what Iranians are entitled to and the resulting obligations of Iran's government. The answers to these questions will show whether the national health laws and policies of Iran are compatible with the provisions of international human rights laws. Realization of the right to health depends upon the political, demographic and socio-economic situation of a country. This chapter depicts the situation of the right to health and its underlying determinants in Iran.

Events such as war and international economic sanctions adversely affect the socio-economic situation of people's lives and call for new policies for the protection of rights. A part of the study that compares the effects of international economic sanctions on selected countries showed that such sanctions negatively affected the health of people.²⁰ Iran has been subjected to international economic sanctions for several years. Chapter 5 addresses the effects of the sanctions on Iranians' right to health and the obligations of the state and the international community in protection of rights. In the period of sanctions, the welfare and living standards of Iranians decreased and their access to the necessities of life such as food, healthcare and medicine became limited. The results of this part of the study were published in the International Journal of Health Policy and Management in 2018.²¹

19 Kokabisaghi, F. 'Justiciability of the Right to Health in the International Legal System' [2016] Iran J Med Law 10(37) 7-33.

20 Kokabisaghi, F. 'Economic Sanctions as Determinants of Health' [2017] Shiraz E-Med J 18(Suppl)e58662

21 Kokabisaghi, F. 'Assessment of the Effects of Economic Sanctions on Iranians' Right to Health by Using Human Rights Impact Assessment Tool: A Systematic Review' [2018] International Journal of Health Policy and Management 7(5) 374-393

A necessary principle for the realization of the right to health is to consider this right in all development plans, laws and policies of states. Very often, national laws and policies directly and indirectly affect the right to health. As an example, a change in a country's resource allocation or establishment of a new production technology can affect the health of the environment or workers. In another case, a change in welfare policies of a country and removing subsidies can affect access of the poor to the necessities of life. Chapter 6 aims to answer the question of whether the new population policies of Iran respect people's right to health. Those policies limit access to family planning services and contraceptives and provide incentives for having more children. In this chapter, health and human rights aspects of the new policy are analysed and recommendations for protecting people's health and human rights are provided. The results of this part of the study were published in the *Journal of Public Health Policy* 2017.²²

- What are the rights of vulnerable groups to health both in law and in practice in Iran?

One of the important principles related to ESCRs, including the right to health, is that everyone, free from any type of discrimination, should enjoy his/her fundamental human rights. State parties to the ICESCR should provide the essential means for vulnerable disadvantaged groups and individuals to enjoy their rights. Women, children, people living with a disability, minorities and refugees might be examples of vulnerable groups. There are several international treaties and national laws and policies concerning the rights of these groups. The related laws and situations of two groups of the population, namely, women and children living in Iran, are analysed in Chapters 7-9. Several sub groups of women and children such as refugees, the disabled and the poor are also included. The reasons for choosing these two groups are given in the next paragraphs.

Worldwide, women are more likely to suffer from discrimination and have low socio-economic conditions that make them particularly vulnerable in health terms. Many health risks such as domestic violence and genital mutilation are borne more by women than by men. Women's illiteracy or lack of health information, their obligation to live and work in unhealthy situations, and their unequal access to resources are the result of inappropriate governmental policies with respect to women. In addition, other issues that originated in particular social attitudes, such as boy child preference adversely affect women's health.²³ States are required by the ICESCR to

22 Kokabisaghi, F. Right to Sexual and Reproductive Health in New Population Policies of Iran [2017] *Public Health Policy* 38(2) 240-256

23 World Health Organisation, *Women and Health: today's evidence tomorrow's agenda* (WHO 2009) XI

remove inequalities and combat such prejudices and discrimination against women and girls by using all necessary means.²⁴ Chapter 7 is on women's right to health in law and practice in Iran. In this part, the totality of women's right to health and the gaps in and barriers to the complete realization of this right are discussed. This part of the study was published in the International Journal of Health Planning and Management in 2019. The study continues with a chapter that addresses an important aspect of women's right to health: the right to control their own health and body.

According to General Comment no. 14 ICESCR, everyone has a right to control his/her health and body and to be free from interference. States are required to prevent third parties from limiting people's access to health services.²⁵ In Iran, male guardians play an important role in the access of married women to some of their rights, including the right to health and social security. In promoting women's right to health, respecting human dignity, which is assumed as respect for autonomy, freedom of choice and participation, is very important. Addressing these values in national laws and policies, and at the level of individuals and health professionals, can significantly affect the enjoyment of women of the right to health.²⁶ Chapter 8 addresses the role of male guardians in women's access to health services in Iran. It was published by the International Journal of Law, Policy and the Family in 2018.²⁷

The suffering of children from maltreatment such as exploitation, violence, and harmful cultural practices is a matter of international concern. Based on international human rights laws, states should protect children and prevent third parties from endangering the health of children or limiting their access to healthcare. In addition, parents without essential means should be supported by the states to provide an adequate standard of life for their children.²⁸ Approximately 22 million children live in Iran; they constitute almost 28% of the population.²⁹ In recent decades, children's survival and health have improved considerably. The main causes of children's diseases and disabilities have been eliminated or controlled in Iran.³⁰ For state parties to the Convention on the Rights of the Child (CRC), it is essential to ensure that

24 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 16 ICESCR: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights* (2005) para19

25 General Comment no. 14 ICESCR, *supra* note 6, para 8

26 *Ibid* at 50

27 Kokabisaghi, F. The Role of the Male Guardian in Women's Access to Health Services in Iran [2018] International Journal of Law, Policy and the Family 32(2)230-249

28 UN Committee on the Rights of the Child, *Convention on the Rights of the Child* 1989, art 19&27

29 United Nations Children's Fund, *The State of the World's Children Report 2015 (Statistical Tables)* (UNICEF, 2015) 38

30 Health Policy Council of Ministry of Health and Medical Education of Iran (MOHME), *Achievements, Challenges and Future of Health System of Iran* (MOHME, Tehran 2010) Summary

domestic legislation is compatible with the Convention's principles and provisions.³¹ Chapter 9 examines the right of different groups of children living in Iran to health and the underlying determinants of that right. The aim of this part is to determine the extent to which national laws and policies on children's right to access healthcare are congruent with international human rights standards. The gaps in providing equal access to healthcare for children are discussed, and recommendations for improving the realization of children's right to health are given. The results of this part of the study was published by the Journal of Law and Medicine in 2016.³²

- What are the necessary steps that Iran should take to improve the realization of the right to health?

According to General Comment No. 14 of the ICESCR all health facilities, services and products should be available, accessible and acceptable to everyone and should be of good quality (AAAQ).³³ In the last chapter, based on the findings of the previous chapters and a review of the health system of Iran, the country's practice of providing AAAQ health facilities, services and products is analysed. Based on that analysis, recommendations for improving domestic laws and their implementation to better reflect international standards of the right to health are provided.

1.3 METHODOLOGY

To perform this study, a qualitative case study design involving a structured document review of relevant laws, policy documents and articles was undertaken. Two sets of literature were studied; the first set was about Iranians' enjoyment of their right to health and the gaps in and barriers to equal access to healthcare. The data were collected from research databases including EBESCO, PubMed, Web of Science, Scopus, Emerald, Elsevier, Cochrane library, Hein online, J Store, Project Muse, Science Direct Springer, Wiley Online Library, Oxford Journals, Embase, SID, and Google Scholar by searching keywords, including "health", "healthcare", "access to healthcare", "medicine", "right to health", "Iran", "human rights", "women", "children" and "economic, social and cultural rights". Supplementary data was acquired by cross checking the reference lists of previously accessed articles and searching the official web pages of Iran's government and the United Nations' health and

31 UN Committee on the Rights of the Child (CRC), *General comment no. 5 CRC: General measures of implementation of the Convention on the Rights of the Child* (2003) para1

32 Kokabisaghi, F. 'Equity in Access to Healthcare for Children: Domestic Implementation of the International Human Rights Law in Iran' [2016] *Medicine and Law* 36(2)59-80

33 General Comment no. 14 ICESCR, *supra* not 6, para 12

human rights committees and organizations such as the WHO, the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the International Labour Organization (ILO), the UN Refugee Agency (UNHCR), the World Bank Group and reports provided by Iran, UN officials and NGOs. The content of the collected papers and documents was analysed in-depth to find evidence of the realization of the right to health in Iran.

The second set of data was about the legal obligations of Iran concerning Iranians' right to health. To identify the gaps in the application of international standards of the right to health, comparing them with Iran's laws is necessary. To acquire relevant international human rights laws and treaties, electronic databases, including the United Nations Treaty Collections and the United Nations Official Document System were scrutinized. In this study, international health and human rights laws refer to laws enacted by the UN Committees and organizations that have an effect on Iran because of their ratification by this country or due to Iran's membership in the legislative organization, such as the ILO and WHO. National law includes Iran's Constitution, legislation and policies related to health and underlying determinants of health. The national laws were acquired from Iran's Parliament Research Centre and the law collection of the Ministry of Health and Medical Education.

To analyse the collected data, appropriate tools are needed. A variety of different scholars, experts and institutions have adopted or developed different tools and techniques for assessing and monitoring the realization of economic, social and cultural rights, and examining whether international provisions have been entered into the domestic legal order and whether public policies have met the purpose and objectives of these rights. Assessment of a country's conduct in fulfillment of the right to health is more complex than simply adopting a set of indicators from the health field. Merely counting cases of maternal mortality is not sufficient to know what should be done to prevent it, as an example. In addition, broad recommendations that merely call for more investment in resources to improve the situation of rights are not helpful to governments. The amount of GDP allocated to the health sector is insufficient to ensure the access of everyone to necessary healthcare. For the assessment of a country's compliance with international human rights treaties, at least two overlapping dimensions of rights should be considered: the extent to which people are (not) enjoying their right to health and the extent to which the government is (not) meeting its obligations regarding everyone's right to health.³⁴

34 Yamin, AE. 'The Future in the Mirror: Incorporating Strategies for the Defence and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda' [2005] *Human Rights Quarterly* 27(4)1200-1244

The conceptual and methodological framework developed by the United Nations Office of the High Commissioner for Human Rights (OHCHR) for the assessment of states' conduct in the realization of international human rights includes three parts: structure, process and outcome. The OHCHR undertook an extensive review of the literature and practices of international and national organisations about monitoring systems for developing this framework in 2006. It has been validated by interviewing experts, piloted by relevant committees and improved in collaboration with UN entities. It is suggested to be used at the country level for translating universal human rights standards into indicators.³⁵ The structural part is related to the ratification of the treaties, the adoption of legal means and the provision of basic institutional mechanisms for the realization of rights. The process part is related to the incorporation of international standards in domestic laws and policies. Process connects the government's programs to milestones in the realization of rights such as the availability, accessibility, acceptability and quality of health facilities, services and products (AAAQ).³⁶ The national policy of a state should be supported by programs of action for the realization of rights and by relevant benchmarks to hold the state accountable for implementing the programs.³⁷ In this framework, national legal provisions are examined at three levels: constitutional, national legislation and policies. A constitution shapes a country's legal framework and defines the rights of the people living in the jurisdiction of a country. National laws frame the governing areas, and national policies determine how to implement national laws.³⁸ Outcome captures the actual realization of a right. Indicators of health status, evidence of discrimination and disparities, and the situations of disadvantaged and vulnerable groups are essential for the evaluation of a state's compliance with its human rights obligations.³⁹

To analyse the data in this study, the conceptual framework developed by the OHCHR has been used. In this respect, the state of ratification of international human rights treaties by Iran, the existence of related national laws and institutions and the current level of the right to health were examined. In some chapters, human rights impact assessment tools are also used. For example, in the parts about the right to sexual and reproductive health in the new population policies of Iran and the role of male guardians in the access of women to health services, the Health Rights

35 Office of the UN High Commissioner for Human Rights, *International Human Rights Instruments, Report on indicators for promoting and monitoring the implementation of human rights* (HRI/MC/2008/3, 2008) p3-4

36 The Office of the United Nations High Commissioner for Human Rights (OHCHR), *Report on Indicators for Monitoring Compliance with International Human Rights Instruments* (U.N. Doc. HRI/MC/2006/7, 2006) 21-26

37 Office of the UN High Commissioner for Human Rights, *supra* note 35 p8

38 Heymann J. McNeill, K. Raub, A. *supra* note 7

39 Leary, V.A. 'The Right to Health in International Human Rights Law' [1994] *Health and Human Rights* 1 (1) 25-56.

of Women Assessment Instrument (HeRWAI) is used. The basis of the instrument is the international legal human rights framework. The instrument assesses the effects of laws and policies on women's right to health by comparing what should have been done based on international and national human rights laws, with what actually happened. In another part of the study about Iranians' right to health during the sanctions period, the Human Rights Impact Assessments (HRIA) tool is used. The aim of this tool is to identify every inconsistency between legal human rights obligations and other national and international obligations. To acquire the necessary data to apply this tool, a systematic review of the literature was performed. In Chapters 7-9 which address the situation of the right to health among vulnerable groups including women and children, the legal framework of accessibility (non-discrimination, physical accessibility, affordability and information availability) determined by General Comment no. 14 of ICESCR is used. According to this document, health services should be provided on the basis which is geographically and economically accessible to everyone and there is no discrimination of any type. Moreover, information concerning these services should be available to all.⁴⁰

In this study, General Comments (GCs) are referred as authoritative legal sources. GCs interpret rights mentioned in a particular human rights treaty. They provide directions for proper implementation of human rights. There are different views on legal relevance of GCs. Some commentators regard them as valuable indications of the content of rights and states' obligations. They do not consider them as having a legal value. Others believe GCs have practical authority because they provide an important body of knowledge and experience in relation to the rights from the angle of a representative treaty. Many others admit that GCs have significant legal weight. According to them, "a committee is the most authoritative interpreter of the treaty it monitors and that state parties are not free to disregard a treaty body's interpretation with which they disagree, despite its non-binding nature."⁴¹ Drafting of GCs is a participatory process that involves multiple interest groups of different context such as NGOs, academics and states' representatives. GCs contribute to the formation of customary international law to shape state practice.⁴²

40 General Comment no.14 ICESCR, supra note 6, para 12

41 Mechlem, K. 'Treaty bodies and the interpretation of human rights' [2009] *Vand. J. Transnat'l L.*, 42, 905-945

42 Ando, N. *General Comments/Recommendations* (Max Planck Institute for Comparative Public Law and International Law 2010)15

1.4 LIMITATIONS OF THE STUDY

In addition to academic literature, in this study official data provided by the government of Iran and international health and human rights organisations are used. However, in general, the government's data on the economic, social and cultural rights and development situation suffers from limited coverage and delayed publication in Iran. Little data on these issues have been collected and published. Occasionally, the data collected by different national institutions are out-of-date, inadequate, contradictory or different. The reports of international organizations suffer from the same limitations.⁴³ Nevertheless, they should not be excluded from the study because they provide insights that might take a long time to get into scholarly sources. In addition, for some sorts of information, such as the number of child workers in the country, official reports of the government might be the only source. Collection of such data usually is beyond the capabilities of individual researchers and institutions. To minimize the study limitations, different data sources were scrutinised and the priority was given to the more recent academic data.

Final note: Chapters 3 and 5-9 are based on publications in international peer reviewed journals and can thus be read independently. The articles are presented as they were published in the journals. The author has attempted to include links between different published parts. However, each journal required an introduction to the subject of the study, such as the right to health, so there are repetitions in some parts of this book.

43 World Health Organisation (WHO), *Country Co-operation Strategy for WHO and Iran* (WHO Country Office in Iran 2004) 30

PART II

HEALTH AND HUMAN RIGHTS



INTRODUCTION

Although the right to health is articulated in several international health and human rights laws and working documents, scholars and policy makers have diverse views of the nature and scope of health as a right and, the related obligations of states. Review of the formulation of this right in the human rights documents and literature is important, since it can be helpful in understanding the normative framework of this right and states' obligations. Chapter 2 is devoted to the right to health, and its relation to other rights and states' obligations. After providing a brief history of human rights, civil and political rights (CPR), economic, social and cultural rights (ESCR) and international and regional human rights treaties, the key formulations of health and the right to health and states' obligations regarding the right to health are explained and analyzed. The principles of non-discrimination and equity in access to healthcare, and the role of health systems in the realization of the right to health are discussed in this section. Chapter 3 addresses the justiciability of the right to health. It answers the question of whether, according to the academic literature on the nature of the right to health and current legal and judicial means, the right to health is a justiciable right.

Chapter 2

Health as a Human Right



2.1 INTRODUCTION

At all times, being a member of a group, such as a family, class, religion, community or state involves individual rights and responsibilities. The tradition of “do unto others as you would like them to do unto you” has been a common tradition in most societies. Universally, all ancient societies have had ethical concepts and a system of duties about human beings. Many of them even correspond to obligations, values and conceptions of justice and political legitimacy related to modern human rights.¹ The Hindu Vedas, the Babylonian Code of Hammurabi, the Bible, the Quran, the Analects of Confucius and the Cyrus Cylinder are six of the oldest written sources that address governments’ and people’s duties and responsibilities. However, they generally lacked a concept of “human rights”; no word for “right” can be found in any ancient or medieval language before 1400 B.C.² Although religious and secular traditions might have shared basic views of a common good, they did not consider every individual equal.³

2.2 HUMAN RIGHTS

At national levels, the promotion of individual rights started long before the Second World War (1939-1945). Examples are the English Magna Carta in 1215 and the Act of Rights and Liberties of the Subject and Settling the Succession of the Crown and the Scottish Claim of Right in 1689, which prohibited some unjust actions of governments. In addition, the Inca and Aztec Codes of Conduct and Justice and the Iroquois Constitution (Native American sources) existed before the 18th century.⁴ The American and French Revolutions were important movements focused on creating national policies based on human rights in the 18th century.⁵ The United States Declaration of Independence and Constitution (1776, 1787) and the French Declaration of the Rights of Man and the Citizen (1787) established certain legal

1 Donnelly, J. *Universal Human Rights in the Theory and Practice* (3rdedn, Cornell University, USA 2013) 71

2 Freeman, M. *Human Rights: an Interdisciplinary Approach* (2ndedn, Polity Press, USA and UK 2001) 16

3 Ishay, M. ‘What are human rights? Six historical controversies’ [2004] *Journal of Human Rights* 3(3) 359-371

4 Shiman, D. *Teaching Human Rights* (Center for Teaching International Relations Publications, University of Denver, 1993) 6-7

5 Forsy, P. D. *Human Rights in International Relations* (2ndedn, Cambridge University Press, 2006) 3

rights.⁶ Furthermore, the Virginia Declaration of Rights (1776) encoded a number of fundamental civil rights and freedoms into law. In the 19th century, abolishing slavery was a considerable step towards the equality of human beings in the United States.⁷ During this century mistreatment of Jews in Russia and Christians in Turkey was noticeable. Establishment of the League of Nations at the end of the First World War (1914-1918), as the first international body that made states accountable for the mistreatment of minorities and indigenous populations in the mandated territories, was a turning point in the protection of people's rights.⁸ Treaties such as the Geneva Conventions of 1864, 1907 and 1929 for the protection of people, including the wounded, civilians and prisoners of war during armed conflicts were drafted to safeguard individual rights.

Among economic, social and cultural rights, a set of rights that received special attention was work-related rights. They originated from the Industrialization era in the 19th century, when poverty and life-threatening work situations (which were accepted as realities of life and a matter of destiny) led specific groups of societies to raise issues with landowners and local lords. Workers' complaints and the high rate of work-related injuries were incentives for countries to enact rules for factories about worker safety, the provision of health services and compensation to address work injury, disability, old age, and unemployment. In the 20th century, the strong position of workers in the market resulted in access to social services, insurance and healthcare. Considerable efforts were made to promote labour rights through an international organization. With the establishment of the International Labour Organization (ILO) in 1919, the content of labour rights was developed.⁹ Some protected rights in the Constitution of the ILO are rights to occupational safety, compensation in case of work injury, creating and joining unions and striking. This organization was the most successful human rights international organization in terms of standard setting and enforcement techniques established before the foundation of the United Nations. However, these rights were not the rights of all people, particularly vulnerable social groups, who often were not able to satisfy their basic needs; instead, they were only for workers who had permanent jobs and consequently were better able to access social benefits.¹⁰

6 Renteln, D. A. *International Human Rights: Universalism Versus Relativism* (Quid pro books, New Orleans 2013)17

7 Eide, A. 'Economic, Social and Cultural Rights as Human Rights', in Eide, A. Krause C. Rosas, A. (eds) *Economic, Social and Cultural Rights; a text book* (Martinus Nijhoff Publishers, The Netherlands, 1995) 27

8 Renteln, D. A. Supra note 6 at 17-19

9 Haxhiraj, A. 'Judicial Enforcement of Economic, Social and Cultural Right' [2013] *Academicus International Scientific Journal* MMXIII (8) 221-230

10 Renteln, D. A. Supra note 6 at 18-19

The First World War (1914–1918) and the Second World War (1939–1945) were major transformative events in the 20th century. Considerable movement for human rights in the 20th century originated from the atrocities that occurred during these two world wars.¹¹ Until 1945, before the establishment of the UN, human rights were mainly national issues. In the 20th century, approximately 35 million people died in armed conflicts, and perhaps 150-170 million people were killed by their own governments through preventable political murder or mass misery.¹² Many individuals were forced to abandon their property to move to new lands. Periods of hunger were common even in relatively prosperous Western Europe. Families were separated for long periods, particularly from their fathers. Horrendous crimes, such as the Holocaust and its abuses, were committed by fascist powers against humanity.¹³ These issues encouraged countries to establish an international organization to promote world peace and prevent more wars. The United Nations (UN) was founded in 1945; Article one of the Charter of the UN defines the purpose of establishing this organization as “to maintain international peace and security,{...} to develop friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples,{...}to achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion; and to be a centre for harmonizing the actions of nations in the attainment of these common ends.”¹⁴

Very soon, it appeared that the Charter was not sufficient for the protection of people’s rights. Moreover, no controlling system, standards or modes of enforcement were designed for the assessment of countries’ compliance with the Charter. In addition, a country’s signature on the Charter does not mean that the country will take steps to respect the Charter and to undertake related obligations.¹⁵ Therefore, several eminent politicians and scholars in various international conferences drafted a different bill of people’s rights. Some sub- committees and working groups were established to work on certain human rights issues, such as child labour, but the notion of “rights” has not been entered into treaties. The international community decided never to allow atrocities to occur again; world leaders devised a road map to guarantee the rights of every individual everywhere as a complement to the UN

11 Forsy, P. D. *supra* note 5 at 3

12 Rummel, R. J. *Death by government* (Transaction Publishers, New Jersey 1997) 24

13 Kesternich, R. Siflinger, B. Smith, P. J. Winter, K. J. ‘The Effects of World War II on Economic and Health Outcomes across Europe’ [2014] *The Review of Economics and Statistics* 96 (1) 103-118.

14 Charter of the United Nations 1945, art 1, 55, 56

15 Renteln, D. A. *Supra* note 6 at 18

Charter. That road map was the Universal Declaration of Human Rights (1948).¹⁶ The Declaration was inspired by Franklin Roosevelt's third Inaugural Address to the Congress in January 1941 (He had been the president of the USA from 1933 to 1945). He wished for four types of freedoms for the world: freedom of speech, freedom of worship, freedom from want, and freedom from fear.¹⁷ The Universal Declaration of Human Rights that defines the totality of rights was agreed without any negative votes of the UN members in 1948. According to this declaration, "recognition of 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". It added that everyone is born free and equal in dignity and rights and is entitled to all human rights and freedoms (mentioned in the Declaration) without distinctions of any type.¹⁸ Later, human rights discourse was broadened internationally.

In 1966, two separated human rights treaties were drafted: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Over a period of years, almost all countries ratified both covenants. In 1993, the High Commission for Human Rights was established by the United Nations General Assembly. In the 1990s, the International Criminal Court was established by the UN Security Council to investigate violations of the laws of war, genocide and crimes against humanity in certain countries.¹⁹ Other developments in the area of human rights have been about more attention to the universality of these rights, and the adoption of domestic public policies for the realization of human rights and the rights of specific groups within populations.²⁰ The International Covenant on the Elimination of all Forms of Racial Discrimination (1965), the Convention on the Elimination of all Forms of Discrimination against Women (1979), the Convention on the Rights of the Child (1989), and the Convention on the Rights of People living with Disabilities (2006) are examples of this approach. Now, human rights are common public policies worldwide.

16 United Nations, 'History of The Universal Declaration of Human Rights' (UN 2016) <<http://www.un.org/en/sections/universal-declaration/history-document/index.html>> accessed 2 May 2016

17 Morphet, S. Economic, Social and Cultural Rights; the Development of Governments' Views 1941-88 in Beddard R. Dilys M. Hill (eds) *Economic, Social and Cultural rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 76

18 Universal Declaration of Human Rights 1948, preamble

19 Baruchello, G. Johnstone R. L. 'Rights and Value: Construing the International Covenant on Economic, Social and Cultural Rights as Civil Commons' [2011] *Studies in Social Justice* 5 (1) 91; Dilys M. Hill, 'Rights and their Realization' in Beddard R. Dilys M. Hill (eds) *Economic, Social and Cultural Rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 2-8; Donnelly, J. Whelan, D. J. 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight' [2007] *Human Rights Quarterly* 29 (4) 908-949

20 Forsy, P. D. *Human Rights in International Relations* (2nd edn, Cambridge University Press, 2006) 4

At the regional level, a number of treaties such as the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), the European Social Charter (1961), the Revised European Social Charter (1996), the African Charter on Human and Peoples' Rights (1981), the African Charter on the Rights and Welfare of the Child (1990), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003), the American Convention on Human Rights (1969), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988) were drafted. The Cairo Declaration of Human Rights in Islam (1990), which was drafted by members of the Organization of the Islamic Conference (composed of 57 countries mainly located in Asia and Africa) is a treaty recognizing human rights according to Sharia. Unlike other continents, Asia, which is a large region composed of countries that are extremely diverse in culture and values and are frequently critical of Western models of political liberalism, has not established any inter-governmental Asia-wide organization for human rights.²¹

2.2.1 What is a Human Right?

The Oxford English Dictionary defines a “right” as a “legal, equitable, or moral entitlement or justifiable claim (on legal or moral grounds) to have or obtain something, or to act in a certain way; the advantage or profit deriving from this; a legal, equitable, or moral title or claim to the possession of property or authority, the enjoyment of privileges or immunities, etc.; (by extension) an entitlement considered to arise through natural justice (whether or not enshrined in legislation) and which is applicable to all members of a particular group.”²² Rights are inherent to the human person and essential for the life of a human being and are defined based on individuals' needs. These needs are endless and diverse for different people, who belong to different groups and communities worldwide. The background of the values of a certain society determines what is meant by the need and consequently which rights can be claimed.²³ Realizing all the rights of people is impossible, even theoretically; therefore, relative policies should be more selective, and priorities should be set. Aston believes that “if every possible human rights element is deemed to be essential or necessary, then nothing will be treated as though it is truly important. A list of requirements that is too demanding or ignores trade-offs and dilemmas is unlikely to be taken seriously by practitioners who are operating under major resource and time

²¹ Ibid at 148-149

²² Oxford English Dictionary online, “right” <<http://www.oed.com/>> accessed 12 May 2016

²³ Dilys, M. Hill, *supra* note 19 at 4

constraints and are faced with competing priorities and the need to make difficult choices.”²⁴ Thus, it is essential to give priority to the protection of certain rights.

According to the Committee on Economic, Social and Cultural Rights (CESCR), human rights are “fundamental, inalienable and universal entitlements belonging to individuals and, under certain circumstances, groups of individuals and communities.”²⁵ Human rights in the Universal Declaration of Human Rights are norms rooted in moralities that demand implementation through national and international legal and political institutions.²⁶ These rights are politically and legally universal. They provide every individual with a legitimate claim upon society for defined benefits and freedoms.²⁷ Having a right means that when someone is denied the right (or is threatened with being denied that right), he is authorized to claim it. Human rights are equal rights; everyone has the same human rights as everyone else. Human rights are inalienable in the sense that no one stops being a human even when he behaves inappropriately. Rights are universal for all members of the human species throughout the world.²⁸ Nowadays, every state has ratified at least one core human rights treaty that reflects its consent to the legal obligations. This is a concrete expression of the universality of rights. Some fundamental human right norms are universally protected by customary international law across all boundaries.²⁹

2.2.2 Evolutions of Human Rights

Evolutions of human rights can be seen in several dimensions. Initially, “the rights of a man” was the right of a white man. It took a long time for the United States, which was one of the frontiers of human rights to include black men in the concept of equal rights in the Constitution and to start the movement for non-discrimination on the grounds of colour, race and national origin. It took even longer to include women, and therefore to change from “rights of men” to “human rights”. Later, the international community recognized that not only adults, but children as independent persons having rights. From another point of view, civil rights, the fundamental achievement of the 18th century were defined on the equality of all people before the law. Political rights, which emerged in the 19th century, are based on participation in

24 Alston, P. ‘Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals’ [2005] Human Rights Quarterly 27 (3) 755-829

25 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 17 ICESCR: The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from Any Scientific, Literary or Artistic Production of Which He or She Is the Author* (2006) para1

26 Nickel, J. W. *Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights* (University of California Press, 1987)107 & 174

27 Donnelly, J. ‘The Relative Universality of Human Rights’ [2017] Human Rights Quarterly 29 (2) 281-306

28 Donnelly, J. *supra* note 1 at 10

29 United Nations office of High Commissioner for Human Rights, ‘What are Human Rights?’ (UN 2016) <<http://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx>> accessed 12 May 2016

the exercise of sovereign power. Social rights as the achievement of the 20th century aim to make it possible for all members of society to enjoy satisfactory conditions of life. More recent achievement of human rights movements is the special protection of individuals who are unable to take care of their needs such as detainees, prisoners and persons with mental illness. Humanitarian law supplements the ordinary human rights protection of persons affected by war or armed conflicts.³⁰

In the literature of human rights, different “generations” of human rights can be observed. The first generation is negative human rights that require abstinence from interfering with personal freedoms. These rights include Civil and Political Rights (CPRs). CPRs that are enshrined in the International Covenant on Civil and Political Rights (ICCPR) include the right to life, the right to be free from torture, the rights to liberty and security of person, the right to freedom of movement, the right to a fair hearing, the right to privacy, the right to freedom of religion and expression, the right to peaceful assembly, the right to family life, the right of children to special protection, the right to participate in the conduct of public affairs, the right to equal treatment, and the special rights of members of ethnic, religious and linguistic minorities.³¹

The second generation of human rights refers to positive rights, or economic, social and cultural rights (ESCRs). The main emphasis of ESCRs is the claim on the state for the protection of vulnerable groups and for assistance.³² They include a variety of rights, such as the right to work and to just and favourable conditions of work, the right to rest and leisure, the right to form and join trade unions and to strike, the right to social security, the right to protection of the family, mothers and children, the right to an adequate standard of living, including adequate food, clothing and housing, the right to the highest attainable standard of physical and mental health, the right to education, and the right to participate in cultural life and to enjoy the benefits of scientific progress.³³

In recent years, a “third generation” of rights including the rights to development and peace has been introduced. The third generation of human rights is a highly complex mixture of rights that sometimes are called “Solidarity Rights”, “Collective Rights” or “People’s Rights”.³⁴ Unlike the two other generations, these rights do

30 Eide, A. *supra* note 7 at 27

31 International Covenant on Civil and Political Rights 1966, part III

32 Eide, A. Rosas, A. ‘Economic, Social and Cultural Rights: A Universal Challenge’ in Eide, A. Krause C. Rosas, A. (eds) *Economic, Social and Cultural Rights; a text book* (Martinus Nijhoff Publishers, The Netherlands, 1995) 11-17

33 International Covenant on Economic, Social and Cultural Rights 1966, part III

34 Freedman, R. ‘Third Generation’ Rights: is there room for Hybrid Constructs within International Human Rights Law?’ [2013] *Cambridge Journal of International and Comparative Law* 4 (2) 935–959

not have solid legal foundations applicable in worldwide legal instruments.³⁵ Most human rights are interrelated and cover different aspects of the same basic concerns: freedom, integrity and equality of all human beings. Their realization depends upon the realization of those rights in other generations of rights. For example, the right to work, which provides an income, can ensure an adequate standard of living; unemployment and insufficient income deprives people of the enjoyment of an adequate standard of living.³⁶

2.2.3 Human Rights Obligations

The obligations of states with respect to CPRs are to respect and ensure that all individuals within a country's jurisdiction enjoy the rights recognized in the ICCPR such as the rights to life and privacy, without distinction of any type. States are required to adopt necessary laws or other measures to give effect to the provisions of the Covenant at the domestic level. Each state should ensure that every person whose rights or freedoms are violated has a right to claim to a competent authority and is entitled to a remedy; governments are required to develop the possibilities of a judicial system that enforces such remedies when granted.³⁷ The ICESCR imposes three different types of obligations on states: to respect people's rights, to protect them from third party interference in their rights, and to fulfill people's rights. Failure to perform any one of these obligations constitutes a violation of such rights. Obligations in the treaty are set conditionally due to the various financial and economic possibilities of state parties. States are required to take steps to achieve the full realization of rights progressively because the full implementation of these rights is not possible in a short period of time for every state. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1986) indicates that "the achievement of economic, social and cultural rights may be realized in a variety of political settings. There is no single road to their full realization. Successes and failures have been registered in both market and non-market economies and in both centralized and decentralized political structures."³⁸

The main duty-bearers of human rights are the state parties to a treaty. However, human rights obligations apply to international actors, such as the World Bank, in relation to the humanitarian dimension of their projects and international co-operation

35 Hannan, M.A, 'Third Generation Human Rights and the Good Governance' [2010] OIDA International Journal of Sustainable Development 2 (5) 41-50

36 Vienna Declaration and Programme of Action 1993, art 5; Eide, A. *supra* note 7 at 31

37 International Covenant on Civil and Political Rights, *supra* note 31, art 2

38 UN Commission on Human Rights, *Note verbale dated 86/12/05 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles")* (E/CN.4/1987/17, 8 January 1987) para 46

too.³⁹ Based on the General Assembly of the United Nations 2002, in international law, the conduct of any organ of a state or non-organ that is empowered by the state to apply elements of governmental authority (exercising legislative, executive, and judicial or any other functions) is considered an act of that state. An organ includes any person or entity holding any position in the organization of a state or at any level of the government (central or territorial) that is given that status by national laws.⁴⁰ In recent years, the role of states has declined; the role of mixed actors, such as international financing and development institutions, the private sector, NGOs and regional and local governments has increased.⁴¹ There are disagreements about the realization of human rights by non-state actors. For example, it is difficult for the private sector to respond effectively to the needs of disadvantaged groups of population. In this sector, administrative costs are often passed onto the insured and achieving cross-subsidization within a private individual-based system is not easy.⁴² Traditionally, non-state actors are considered not to be bound by international human rights law because they are beyond the reach of these laws. Still, some non-legal enforcement mechanisms such as consumer boycotts and ethical investment strategies are suggested to induce human rights compliance.⁴³ Nevertheless, some obligations relating to the right to health, including refraining from interfering in people's enjoyment of their rights, should be fulfilled in both the private and the public sectors. The government is responsible for supporting the disadvantaged groups.

2.2.4 Compliance Evaluation at International Level

UN Committees of Independent Experts monitor the implementation of core human rights treaties. Each human rights treaty has its own monitoring body that meets regularly to review state parties' periodic reports and, through constructive dialogue with states, helps them to better fulfil their human rights obligations. States are required to make the reports available to their populations, according to the principle of transparency. Reports can contribute to the promotion of the debate on human rights issues, help the engagement of civil society, and encourage and facilitate public scrutiny of government policies. Following the review of a state's report, the

39 Dilys M. Hill, 'Rights and their Realization', in Beddard R. Dilys M. Hill (eds) *Economic, social and cultural rights: progress and achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton 1992) 11

40 UN General Assembly, *Resolution A/RES/56/83 on Responsibility of States for Internationally Wrongful Acts* (2002) art 4-5

41 Eide, A. Rosas, A. *supra* note 32 at 18

42 Langford, M. King A. J. 'Committee on Economic, Social and Cultural Rights; Past, Present and Future', in Langford, M. (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press 2009) 508

43 Reinisch, A. 'the Changing International Legal Framework for Dealing with Non-State Actors' in Alston, P. *Non-state Actors and Human Rights* (Oxford University Press 2005) 37-89

CESCR prepares Concluding Observations that include recommendations on how the state can improve its human rights record. States' compliance with the obligations of the ICESCR and the level of rights and duties are monitored by the CESCR. The Committee, essentially bases its judgment on national reports set by the state parties. However, the Committee is also entitled to make use of other information sources, such as the reports of national human rights NGOs. During the reporting process, indicators, national benchmarks, and realistic targets to be achieved in the next reporting period are identified by the Committee and the state.⁴⁴ The emphasis of the supervision is more on dialogue with states rather than on adversarial confrontation. The Committee cannot do more than asking or urging the states to correct the situation, when they are not fulfilling their obligations. There is no possibility of imposing fines or sanctions on states.⁴⁵

2.3 HEALTH AS AN INTERNATIONAL CONCERN

Different threats to health, including transmissible diseases, poor sanitation, inadequate safe drinking water and lack of access to medical care, have been social concerns throughout history. The engagement of religious organizations such as churches, in providing healthcare and charity for the poor and the sick proves this concern. A long time ago, societies accepted the necessity of protecting health, whether for humanitarian, social or economic reasons. In 1907, the Office International d'Hygiène Publique (English: International Office of Public Hygiene) was founded in Paris to administer international rules for the quarantining of ships and ports to prevent the spread of plague and cholera, and administer public health agreements.

In 1920, the League of Nations' Health Organization was established to prevent the spread of communicable diseases. Later, it was replaced by the World Health Organization (WHO). However, because it was poorly understood, for many years, the right to health has actually been marginalized in political and social debates around the globe. After the Second World War, humanitarian concerns, civil society's activities, domestic and regional political programs and global strategic considerations led to the inclusion of health in international law. At that time, health was considered

44 World Health Organization (WHO), *25 Questions & Answers on Health & Human Rights* (WHO, Health & Human Rights Publication Series, Issue No.1, 2002)4-16

45 Schoukens, P. 'The Right to Access to Healthcare: Healthcare According to International and European Social Security Law Instruments', in den Exter, A. P. (ed) *International Health Law Solidarity and Justice in Health Care* (Maklu, Antwerpen 2008) 24

necessary not as a “noble aspiration or utopian goal” but as an achievable goal.⁴⁶ The WHO has had an important effect on this process by defining what is meant by “health” and introducing the right to it.

2.3.1 What is Health?

The Constitution of the WHO (1946) conceptualizes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.⁴⁷ This definition has been influential in articulating the language of the right to health, and is included in several international human rights treaties.⁴⁸ It conveys a positive view of health rather than limiting it to the absence of disease or infirmity, and it includes the physical, mental, and social aspects of health. However, this definition has been subjected to controversy because it lacks an operational value, and it is not clear what the state of complete physical, mental and social well-being is. The ambiguity of the definition brings difficulties in measuring health status and the progress of its improvement. Another criticism is that such a broad definition turns all of human life and its political or economic difficulties into health problems.⁴⁹ In addition, the definition seems to be an ambitious and complex goal that requires an open-ended list of actions by multiple stakeholders to be applied.⁵⁰ It is also unrealistic to believe that everyone can be healthy. In addition to genetic impediments to the attainment of complete health by all, due to the increase of the burden of chronic diseases and the ageing of the world population, complete physical, mental and social well-being will not be achievable for many.⁵¹ In addition, it is argued that this broad definition creates difficulties for both health professionals and policy makers to make it operational.⁵² They need reasonable and workable standards to implement such a goal.

Other definitions have been suggested for health; but the definition of the WHO has been widely used. The CESCR believes that health requires more than medical care and that it depends upon the cultural, economic, social, civil, and political dimensions of life.⁵³ The inclusive definition of the WHO presents the effects of such factors on health. Considering such an aspirational and comprehensive definition for

46 Tobin, J. *The right to health in international law* (Oxford University Press 2012) 14-36

47 Constitution of World Health Organisation 1948, Preamble

48 Toebes, B. *The Right to Health as a Human Right in International Law* (Intersentia 1999) 36.

49 Callahan, D. *The Roots of Bioethics: Health, Progress, Technology, Death* (Oxford University Press 2011) 63

50 Huber, M. Knottnerus, A. J. Green, L. van der Horst, H. Kromhout, D. et al. ‘How should we define health?’ [2011] *BMJ* 343:d4163

51 Yach, D. ‘Health and illness: the definition of the World Health Organization’ [1998] *Ethik in der Medizin* 10 (1) 7-13

52 Ruger, J.P. *Health and Social Justice* (Oxford: Oxford University Press 2010) 122

53 UN Committee on Economic, Social and Cultural Rights, *Summary record of the 41st CESCR meeting* (E/C.12/1993/SR.41, 12 September 1993. Palais des Nations, Geneva) 4

global plans appears appropriate. WHO has introduced specific targets and indicators to resolve measurement issues related to its definition of health.⁵⁴

Health is recognized in international laws and policy documents related to development, health and human rights. The Alma Ata Declaration (1987) is well known for addressing the main health problems in communities and promoting primary healthcare as a means to advance equitable access to all levels of health services.⁵⁵ In September 2000, the Millennium Declaration was adopted by the UN members. In this Declaration, the world's leaders committed to a wide range of programs and action plans for combating poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women. Moreover, the adoption of General Comment No. 14 ICESCR on the right to health was a significant step toward understanding the right to health.⁵⁶ In 2005, WHO members committed to universal health coverage to guarantee everyone's access to essential health services without any risk of financial ruin or impoverishment. This initiative has resulted in considerable advancement in the provision of health services and in financial risk protection.⁵⁷

2.3.2 Right to Health

The first notion of a legal right to health (mentioned as medical care) under international law can be found in the Universal Declaration of Human Rights (1948). Article 25 of this Declaration indicates that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".⁵⁸ The linkage between human rights and health has been one of the considerable advances in the history of health. However, the Declaration does not define the components of a right to health. The ICESCR defined the right to health and determined a short list of steps for the realization of this right. Later, this right was recognized by several international human rights treaties such as Article 5 (e) (iv) of the International Convention on the Elimination of all Forms of Racial Discrimination (1965), Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979), Article 24 of the Convention on the Rights of the Child (1989) and Article 25 of the Convention on the Rights of People living with Disabilities (2006).

⁵⁴ Yach, D. *supra* note 51

⁵⁵ World Health Organization, *The World Health Report 2013: Research for Universal Health Coverage* (WHO, 2013) 6

⁵⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment no. 14 ICESCR, The Right to the Highest Attainable Standard of Health* (2000) paras 4&17

⁵⁷ WHO, *Resolution WHA58.33. Sustainable Health Financing, Universal Coverage and Social Health Insurance*. (In: Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005. Volume 1. Resolutions and decisions. Geneva, World Health Organization, 2005 (Document WHA58/2005/REC/1)).

⁵⁸ Universal Declaration of Human Rights 1948, *supra* note 18, art 25.1

Moreover, several regional human rights instruments recognized the right to health. Examples are Article 11 of the European Social Charter of 1961, Article 16 of the African Charter on Human and Peoples' Rights of 1981, Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 and Article 17 of the Cairo Declaration of Human Rights in Islam (1990).

Article 12 of the ICESCR defines the right to health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁵⁹ The manner in which a state frames a right determines the type and amount of resources that will be allocated to realize that right. The right to health can be defined differently, ranging from avoiding interference in people's enjoyment of their right to health to taking minimal actions, such as the provision of primary healthcare for the poor, or taking extensive actions, such as providing shelter and food, or empowering individuals to make decisions about their own health.⁶⁰ According to General Comment no. 14 of the ICESCR, the right to health is not a right to be healthy or a right to perfect health, and states cannot ensure good health for everyone, nor can governments protect people from every cause of ill health. The right to health is a right to the enjoyment of facilities, services and products related to health and its underlying determinants that provide the necessary conditions for the enjoyment of the highest attainable level of health. The right to health includes a right to equal and timely access to basic preventive, curative, and rehabilitative health services, essential drugs, and regular screening programs. It also includes the appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, and appropriate mental health care.⁶¹

The right to health is driven from the inherent worth and dignity of human beings; it is related to and dependent upon the realization of other human rights, such as the right to life, human dignity, non-discrimination, equality, food, education, work, and housing, and the prohibition of torture. This right encompasses a set of socio-economic factors that provide the conditions for people to have a healthy life. This right includes the right to the underlying determinants of health such as food, housing, safe and potable water and appropriate sanitation, safe and healthy working conditions, and a healthy environment. Health-related education and information and participation in health-related decision-making are parts of this right too. The right to health encompasses the right to control one's health and body and to be free from interference, torture, and non-consensual medical treatment and experimenta-

⁵⁹ International Covenant on Economic, Social and Cultural Rights (ICESCR), *supra* note 33, art 12

⁶⁰ Harvard Law School, *Economic and Social Rights and the Right to Health; an Interdisciplinary Discussion* (Massachusetts, September 1993) 3

⁶¹ *General Comment no. 14 ICESCR, supra* note 56, paras 4&17

tion and the right to a system of health protection that provides equal opportunity for everyone to enjoy the right to health and the underlying determinants of health.⁶²

2.3.3 States' Obligations Concerning the Right to Health

Currently, most countries have accepted at least one of the international or regional covenants or treaties recognising the right to health. 160 countries ratified the IC-ESCR and 135 countries incorporated the right to health or duties of the state with respect to people's health into their constitution by 2009.⁶³ Governments decide freely whether to join an international treaty; as soon as they make this decision, there is a commitment to act in accordance with the provisions of the treaty.⁶⁴ Based on the Vienna Declaration and Program of Action in 1993, all states, regardless of their economic, political and cultural systems, are to promote and protect all fundamental human rights and freedoms.⁶⁵ National and regional specifications and different historical, cultural and religious backgrounds might affect how the rights are realized but not the content of rights. States are required to provide a minimum level of every right for everyone and then to improve the situation of each right. The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1997) indicate that "steps towards the full realization of rights must be deliberate, concrete and targeted as clearly as possible towards meeting a government's human rights obligations. All appropriate means, including the adoption of legislative measures and the provision of judicial remedies as well as administrative, financial, educational and social measures must be used in this regard."⁶⁶ States are required by Article 12 of ICESCR to take the following steps in realization of the right to health:

- a. The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; (according to General Comment no. 14 ICESCR, recently, infant and under-five mortality rates are measured instead of stillbirth rate.⁶⁷)
- b. The improvement of all aspects of environmental and industrial hygiene;
- c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- d. The creation of conditions which would assure everyone's access to all medical services and medical attention in the event of sickness.⁶⁸

⁶² Ibid, paras 3&8

⁶³ Hogerzeil, H. V. Mirza, Z. *The World Medicines Situation 2011, Access to Essential Medicines as Part of the Right to Health* (WHO Department of Public Health, Innovation and Intellectual Property, Geneva, 2011) 6-7

⁶⁴ World Health Organization (WHO) *supra* note 44 at 12

⁶⁵ Vienna Declaration and Programme of Action 1993, art 5

⁶⁶ *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) part II

⁶⁷ General Comment no. 14 ICESCR, *supra* note 56, para 14

⁶⁸ ICESCR, *supra* note 33 at 12

Based on the obligation of respect, states are required to refrain from denying or limiting the enjoyment of people of the right to health and its underlying determinants. The obligation to protect necessitates that states employ all essential means to prevent third parties from interfering in people's enjoyment of their rights. The obligation to protect is rooted in concern for the enhanced role of the private sector in societies.⁶⁹ States are required to regulate, inspect and monitor private parties' conduct and to consider enforcing administrative and judicial sanctions against non-compliant third parties, such as employers, healthcare providers, private food and water suppliers and, potentially polluting industries.⁷⁰ The obligation to fulfil includes duties of the states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures toward the full realization of the right to health.⁷¹

The obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to facilitate requires states to establish conditions that enable individuals and communities to enjoy their right to health. In this respect, necessary means including appropriate legislation and a national strategy and plan of action for the realization of the right to health should be adopted and implemented. In addition, the states should ensure that relevant systems, such as social security and health systems are adequate and accessible to the entire population. To fulfil the obligation to promote, states are required to create, maintain and restore the realization of rights by appropriate education and public awareness. Based on the obligation to provide, the state should provide means for individuals and groups who are unable to realize their rights because of conditions that are accepted as being beyond their control. Examples include the poor or people belonging to lower-income groups, disadvantaged and marginalized women, persons living with disabilities, asylum seekers, refugees and internally displaced persons, the elderly, children, indigenous people, minorities, and the homeless.⁷² States are required to identify problematic situations, provide relief, and create conditions for right-holders to access the provisions protected by law. The obligation to fulfil can consist of the direct provision of basic needs, such as food when there is no other possibility to access it, for example in the

69 *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) supra note 66, para 18; General Comment no. 14 ICESCR, supra note 56, para 33

70 Saul, B. Kinley, D. Mowbray, J. *The International Covenant on Economic, Social and Cultural Rights* (Oxford University Press, 2014) 631

71 General comment no. 14 ICESCR, supra note 56, para 33

72 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 19 ICESCR: The Right to Social Security* (2008) paras 48-50

case of unemployment or during recessions, crisis or disasters, for disadvantaged and marginalized groups and individuals.⁷³

According to General Comment no. 14 of the ICESCR, health (and its underlying determinants) facilities, services and products should be available, accessible, acceptable to everyone, and of appropriate quality (AAAQ). Availability requires that health facilities, services and products be provided in sufficient quantity throughout the country's jurisdiction. An adequate number of skilled medical personnel, scientifically approved and unexpired medicines and hospital equipment, safe water, and sanitation should be provided to everyone without any types of discrimination. Accessibility includes the four dimensions of non-discrimination, physical and financial accessibility and information availability. Health facilities, services and products should be accessible to everyone, particularly the most vulnerable and marginalized groups of the population and individuals. In addition to prohibiting discriminatory practices, the legislation should contain special measures granting protection to vulnerable or disadvantaged groups, such as children and indigenous people. Health facilities, services and products should be physically accessible and within a safe physical reach of everyone including women, the elderly, children, indigenous people, and persons living with disabilities or HIV/AIDS. Appropriate incentives should be offered to attract physicians and other healthcare providers to deliver services in underserved geographic areas.⁷⁴

Moreover, whether privately or publicly provided, health facilities, services and products should be affordable for all; states have an obligation to support those who lack sufficient means to enjoy their right to health.⁷⁵ It is a principle that no one who needs healthcare should be denied because of inability to pay.⁷⁶ To fulfil this goal, the WHO suggested that there should be no out-of-pocket payments above a given threshold of affordability. That threshold is usually set at zero for the most disadvantaged and the poorest individuals and groups of population.⁷⁷ In addition, information about health issues and the right to health should be accessible to everyone. People should have the opportunity to seek, receive and impart information and ideas concerning health issues. Acceptability requires the government to ensure that all health facilities, services and products are culturally appropriate and respectful of medical ethics. Finally, all health facilities, services and products should be of good quality and scientifically and medically appropriate.⁷⁸

⁷³ International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights, Comparative Experiences of Justiciability* (International Commission of Jurists, Geneva, 2008) 53

⁷⁴ World Medical Association Statement on Access to Health Care 2006, art 34

⁷⁵ General comment no. 14 ICESCR, *supra* note 56, para 12

⁷⁶ World Medical Association Statement on Access to Health Care, *supra* note 74, art 34

⁷⁷ World Health Organisation, *supra* note 55, at 7

⁷⁸ General comment no. 14 ICESCR, *supra* note 56, para 12

2.3.4 Minimum Core Content of the Right to Health Obligations

The definitions of health and the right to health are very broad; consequently, state obligations are broad and costly. However, such challenges do not mean that low income countries cannot realize this right because they do not have the resources to provide expensive health services. Parts of the right to health can be realized at a low cost. In addition, states are required to make policies and action plans that will progressively lead to accessible healthcare for all in the minimum time possible.⁷⁹ Every state has specific conditions and capabilities, such as human and financial resources, transportation systems and public education. In addition, the health situation of populations and their needs and demands are different. These factors influence the approach of a country and the priorities for the realization of the right to health.⁸⁰ Governments should allocate health the sums it deserves from the national budget. Priority should to be given to prevention and cost-effective health services.⁸¹

A primary obligation of state parties to the ICESCR concerning the right to health is to ensure minimum health conditions for all and thereafter to progressively improve these conditions to achieve the highest attainable standard of physical and mental health for all. Based on General Comment no. 14 of the ICESCR, core obligations relating to the right to health are providing universal access to health facilities, services and products (including reproductive, maternal and child health-care, essential medicine, immunization and health information), minimum essential food, basic shelter, sanitation and safe water.⁸² Minimum core obligations are the first step in realizing ESCRs. According to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights “such minimum core obligations apply irrespective of the availability of resources of a country concerned or any other factors and difficulties.”⁸³ General Comment no.3 of the ICESCR on the nature of states parties obligations indicates that “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a state party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary healthcare, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant.”⁸⁴ To fulfil the minimum core

⁷⁹ World Health Organization (WHO), *supra* note 44, at 9

⁸⁰ World Medical Assembly Statement on Access to Health Care, *supra* note 74, Preamble

⁸¹ United Nations Committee on Economic, Social and Cultural Rights (CESCR), *Summary record of the forty-second meeting*, 6 December 1993 (C.12/1993/SR.42, 1994) 49

⁸² General Comment no. 14 ICESCR, *supra* note 56, Paras 43-44

⁸³ Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, *supra* note 66, para 9

⁸⁴ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment no. 3 ICESCR: The Nature of States Parties' Obligations* (1990) para 10

obligations of the right to health for all, a health sector paradigm should follow these objectives:

- Providing basic standards of health to everyone in the country in an equal manner,
- Removing existing inequities in the distribution of health sector resources and bringing disadvantaged groups up to mainstream levels,
- Considering health services as a public good and not treating them as a profit-making commodity,
- Recognition of legally enforceable entitlements of individuals and provision of low-cost and accessible mechanisms for people to seek for remedies in the case of violations of their right to health,
- Facilitating participation of individuals and groups in priority setting and monitoring of health sector activities and financing healthcare.⁸⁵

2.3.5 Progressive Realization

According to the ICESCR, states are required to use the maximum available resources to progressively realize ESCRs, including the right to health.⁸⁶ Because of the differences in available resources and the population's health situation in different countries, it is difficult to set universally applicable standards and obligations for all. Every country should define national benchmarks for ESCRs in accordance with the full range of obligations and maximum available resources.⁸⁷ In the development of a right to adequate healthcare, a poor and a rich country might have different benchmarks. However, some rights, such as freedom from discrimination are not progressive and no matter where they are practiced, constitute universal standards for all countries. Progressive realization indicates that states can decide what steps to take to address ESCRs obligations as long as they reflect constant progress. An implication arising from progressive realization is that at least the present level of enjoyment of rights should be maintained.⁸⁸ Progressive realization requires all countries to move as expeditiously and effectively as possible toward full realization of rights.⁸⁹

Not all obligations of the ICESCR are progressive; some of them are immediate. Examples are equal treatment of men and women and the prohibition of discrimination, the prohibition against adopting retrogressive measures in the realisation of

⁸⁵ United Nations Committee on Economic, Social and Cultural Rights, *supra* note 81, at 49

⁸⁶ ICESCR, *supra* note 33, art 2

⁸⁷ Office of the UN High Commissioner for Human Rights, *Economic, Social and Cultural Rights: Handbook for National Human Rights Institutions* (Professional Training Series No.12, UN, New York and Geneva, 2005)66

⁸⁸ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt* (A/HRC/7/11, 31 January 2008) part 8

⁸⁹ World Health Organization, *supra* note 44, at 16

rights and the obligation to meet minimum core obligations. In addition, some rights, which can be characterized as freedoms, should be realized immediately. For example, freedom from inhumane treatment and forced medical examinations or sterilization is of immediate effect and is not related to the availability of resources. The same is applicable to the protection of individuals from third parties' interference in the enjoyment of their rights.⁹⁰ When a retrogressive measure is taken, the state should provide evidence of careful consideration of all alternatives and maximum available resources. When resource constraints make it impossible for the state to fulfil its obligations, the state should provide evidence that every effort has been made to maintain the current level of the rights. However, according to General Comment no. 14, non-compliance with the core obligations of the right to health cannot be justified under any circumstances. In the case of economic crisis and severe financial limitations, there is the possibility to seek help from the international community.⁹¹

Even though, the notion of using the maximum of available resources is relevant to both poor and wealthy countries, it has different implications for each; a rich country should have a higher standard than a low- or middle-income country.⁹² All countries should show that they are willing to realize the right to health and to make constant progress toward the full realization of this right. Moreover, not all elements of the right to health demand considerable resources. Many important measures to protect and promote the right to health are not expensive and can be adopted by all countries, no matter what their level of economic development is. For example, even with very limited resources, discrimination can be addressed by appropriate guidelines.⁹³

In the allocation of resources more emphasis should be given to preventive services compared with expensive medical procedures and priority should be given to primary or community healthcare facilities rather than high technology and capital-intensive ones.⁹⁴ In addition, the special needs of the most disadvantaged and vulnerable groups should be met first. As a state takes retrogressive measures in realisation of rights, it is important to distinguish between the inability and the unwillingness of the state to fulfil the obligations. The CESCR has promulgated measures to examine a country's justification of unavailability of resources for adopting retrogressive measures. These measures include assessing the severity of the alleged breach, the proximity of the minimum essential level of the right, the level of the country's development and economic situation, whether the country has sought low-cost alter-

90 Office of the UN High Commissioner for Human Rights, *supra* note 87, at 11

91 General Comment no. 14 ICESCR, *supra* note 56 para 38

92 UN General Assembly, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 entitled "Human Rights Council"* (A/HRC/4/28, 17 January 2007) 15

93 Committee on Economic, Social and Cultural Rights, *supra* note 53, at 8

94 United Nations Committee on Economic, Social and Cultural Rights, *supra* note 81, at 49

natives and international co-operation and assistance to maintain its current level of rights, whether the measures are discriminatory, and whether a lack of resources will have a constant effect on the realization of the right.⁹⁵

2.3.6 Non-discrimination and Human Rights

Endeavours to promote equality of human beings received attention when poor workers in life threatening workplaces protested against landowners and local lords before the Industrialization era, a time when poverty and unequal access to resources were accepted as realities of life for specific groups of society.⁹⁶ The United Nations' Charter is the first international treaty that affirmed "faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women".⁹⁷ Later, Article 25 of the Universal Declaration of Human Rights recognized the equality of all human beings in dignity and rights.⁹⁸

Governments are required by two Human Rights Covenants (ICCPR and ICESCR) to prevent any discrimination on internationally prohibited grounds including race, colour, sex, language, religion, property, national or social origin, political or other opinion, birth or other status in the enjoyment of fundamental rights, such as access to healthcare and underlying determinants of health.⁹⁹ However, disparities in access to the necessities of life between men and women, children and elderly people, poor and rich, villagers and urbanites and citizens and refugees can be observed throughout the world. The differences are larger for advanced healthcare than for primary healthcare. People belonging to lower socio-economic groups are more likely to have higher rates of disease, disability and death. They often use fewer health services than they need and might be required to pay a disproportionately higher share of their income for health services.¹⁰⁰ Frequently, it has been reported that the poor have more health needs than the well-off. In addition, disadvantaged and poor groups are vulnerable to other abuses of their human rights. The main roots of poverty are unemployment and insufficient income which are frequently associated with illiteracy and ill-health. Poor people do not have power or political

95 General Comment no. 19 ICESCR, supra note 72, para 42

96 Haxhiraj, A. supra note 9

97 Charter of the United Nations 1945, supra note 14, preamble

98 Universal Declaration of Human Rights, supra note 18, art 1

99 International Covenant on Civil and Political Rights supra note 31, art 2; ICESCR, supra note 33, art 2

100 de Looper, M. Lafortune, G. *Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries* (OECD Health Working Papers, No. 43, OECD Publishing, Paris, 2009) 3

tribunals; thus, in case of disaster, famine or environmental pollution, they are the first to suffer.¹⁰¹

Discrimination is defined by General Comment no. 20 of the ICESCR as “any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing of Covenant rights.”¹⁰² According to the WHO, health systems are often inequitable, providing higher quality and more services to the rich, who need them less, than to the poor, who need more and are unable to obtain them. In the absence of measures to ensure disadvantaged groups are effectively reached by the health system, such inequalities will continue.¹⁰³ Inequity is an unnecessary and avoidable difference in access to available care for equal need. Unequal treatment of equal cases is discrimination.¹⁰⁴ According to the CESCR, through the adoption, modification or abrogation of legislation, discrimination related to health and its underlying determinants can be eliminated with minimum resource implications. Based on General Comment no. 3 ICESCR on the nature of state parties’ obligations, the vulnerable groups of society should always be protected, even in times of severe shortage of resources, through the adoption of relatively low-cost targeted programs.¹⁰⁵ A range of techniques have been used to improve the access of the poor to necessary services. They include adopting proper means for identifying poor individuals, cash payments for the use of services, and use of non-governmental organizations to provide pro-poor services.¹⁰⁶

2.3.7 Health System and the Right to Health

Since people began to protect their health and treat diseases, some types of health system have existed. However, organized health systems have not existed further back than approximately 100 years ago, even in the developed world. They have gone through several developments and reforms and have been framed by national and international values and goals. According to the WHO, currently, health systems in many countries are failing and collapsing. Health services are often accessible to

101 Hausermann, J. ‘The Realization and Implementation of Economic, Social and Cultural Rights’, in Beddard R. Dilys M. Hill (eds) *Economic, Social and Cultural Rights: Progress and Achievement* (Macmillan in association with the Mountbatten Center for International Studies, University of Southampton, 1992) 57

102 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 20 ICESCR: Non-Discrimination in Economic, Social and Cultural Rights* (2009) para 7

103 Gwatkin, DR. Bhuiya, A. Victora, CG. ‘Making Health Systems More Equitable’ [2004] *Lancet* 364 (9441) 1273-1280.

104 Whitehead, M. ‘The Concepts and Principles of Equity and Health’ [1992] *International Journal of Health Services* 22, 429-445

105 General Comment no. 3 ICESCR, *supra* note 84, para 12

106 Gwatkin DR, Bhuiya A, Victora CG. *Supra* note 103

certain groups of the population. Many health systems are unsafe, inequitable and regressive and health outcomes are much lower across many developing countries. Moreover, deep inequities in health status persistently exist worldwide. Failure of health systems is at the centre of this problem.¹⁰⁷ In addition, human rights principles are not considered in most health-system reforms, and the reforms tend to focus on market policies.¹⁰⁸ This approach prioritizes expensive procedures, such as complicated surgeries needed by small parts of the population, over cheap prevention services needed by a larger part of the population because the financial benefits of expensive procedures are greater than those of preventive services. In addition, the focus of health systems is mostly on diseases rather than on the person as a whole, whose mind and body are linked and should be treated with respect and dignity.¹⁰⁹

Demand for healthcare always exceeds supply, and as a result, there will be people requiring necessary care but not having access due to a lack of resources. Nowadays, efficiency is one of the main aims of healthcare system reforms to respond to patients' increasing needs for medical care and the scarcity of resources.¹¹⁰ The problem with healthcare rationing is that in a system of implicit rationing, individuals with lower socio-economic status inevitably fall victim to inequality which is a violation of human dignity. It is important to make choices that benefit a larger population. The example is the vaccination of newborns instead of an expensive artificial hearts for the elderly.¹¹¹ Currently, governments are considering whether specific expensive therapy or medicine covered by national healthcare benefit package should be provided. In the most extreme cases, it even can result in death for patients with life-threatening diseases.¹¹² It is important that minimum standards and human rights conventions be considered as standard setting instruments in making health policies.¹¹³ In this system, decisions need to be the result of comprehensive, systematic, rational and transparent deliberation. Moreover, they should be verifiable, visible, and legitimized in a democratic manner.¹¹⁴

Another suggested solution for tackling the problems of scarcity of resources is to introduce competition into healthcare. However, concerns about the benefits of

107 Ibid

108 San Giorgi, M. *The Human Right to Equal Access to Health care* (The Netherlands: Intersentia; 2012) 1

109 World Health Organization, *People at the Center of Health Care* (WHO, Geneva, 2007) 7

110 den Exter, A. 'Access to healthcare; solidarity and justice' [2008] *Med Law* 27, iii-vi

111 Buijsen, M. 'the special moral status of health care. on market forces, equal treatment, and having a say' in den Exter, A. Buijsen, M. (eds) *Rationing Health Care: Hard choices and unavoidable trade-offs* (Maklu, 2012) 197-208

112 den Exter, A. 'Cost-effectiveness analysis: What's law got to do with it?' [2014] *Medicine and Law* 2(2) 249-297

113 den Exter, A. *supra* note 110

114 Buijsen, M. *supra* note 111

efficiency and equity should be addressed together.¹¹⁵ Privatization can be justified for economic reasons such as cost-reduction and improvement of efficiency. But it is necessary to regulate health systems to respect fundamental human rights and principles such as equal access to healthcare and the equality of persons and solidarity.¹¹⁶ Traditionally, solidarity and equal access are the basis of health insurance systems. Buijsen indicates that “solidarity refers to actual understanding of union and commitment and subsequent willingness to share the risks inherent to human existence.”¹¹⁷ The key principle in healthcare systems should be solidarity. It means that everyone should have access to healthcare based on medical needs, not ability to pay.¹¹⁸ Human rights law introduces a unique and uncompromising notion of justice in the field of health care. Distribution of health care is distribution on the basis of need.¹¹⁹ Justice and equality are very important in the field of healthcare. Equality in healthcare entails equal material opportunities; it only exists in the sphere of justice. The intrinsic value of health as a goodness compels demand for equal access to health system resources.¹²⁰ The shift towards a competitive health insurance market and freely negotiated prices and premiums that are not based on people’s income will serve the wealthy more than the poor population. In this situation, the poor are less likely to take basic or supplementary insurance coverage because of an inability to afford it.¹²¹

The right to the highest attainable standard of health is the right to an integrated and effective health system that includes health and its underlying determinants, provides equal access for everyone and is responsive to national and local priorities.¹²² The essential components of an effective health system relevant to both developed and developing countries suggested by the Alma Ata Declaration are equity, community participation, a multi-sectoral approach to health problems, effective planning, integrated referral systems, health-promotional activities, trained human resources, and international co-operation.¹²³

115 den Exter, A. Guy, M. J. ‘Market competition in health care markets in the Netherlands: some lessons for England?’ [2014] *Medical law review* 22(2) 255

116 den Exter, A. ‘Health system reforms in the Netherlands: from public to private and its effects on equal access to health care’ [2010] *Eur. J. Health L* 17, 223

117 Buijsen, M. ‘the meaning of Justice and solidarity in healthcare’, in den Exter, A. (ed) *International health law solidarity and justice in healthcare* (Maklu, 2008) 51-61

118 Jost, T. S. Dawson, D. den Exter, A. ‘The role of competition in health care: A western European perspective’ [2006] *Journal of Health Politics, Policy and Law* 31(3) 687

119 Buijsen, M. ‘The Meaning of Justice in Health Care [2008] *Med & Law* 27, 535

120 Buijsen, M. den Exter, A. ‘Equality and the right to healthcare’. in den Exter, A. (ed) *Human rights and Biomedicine* (Maklu, 2010) 69-85

121 Buijsen, M. “Market reforms and health care access in the Netherlands” [2015] *Bioethica Forum. Schweizer Zeitschrift für Biomedizinische Ethik* 3, 100

122 UN General Assembly *supra* note 92, at 15

123 Alma Ata Declaration 1987, part VII

For a country that is willing to realize the right to health, having a national strategy and action plan with a timeframe for the achievement of the goals and possible resources and procedures are necessary. Appropriate feasible measures for the realization of the right to health are different for every state. The national health policy should be accompanied with detailed plans for realizing the right to health, including safe motherhood, immunization programs, reproductive health services, safe food, potable and clean drinking water, basic sanitation, healthy lifestyle, and adequate living conditions. Moreover, it should be responsive to new health challenges, such as the spread of HIV/AIDS, and to underlying determinants of health, such as domestic violence and environment pollution. Furthermore, states are required to provide affordable health insurance for all. Accountability, transparency, participation, collaboration with civil society and non-discrimination should be considered, and a legal framework to implement and monitor the national strategy should be advised.¹²⁴ To make such a plan and monitor its implementation, having an appropriate health information system is essential. Data on the situation of health and its underlying determinants should be regularly collected, analysed and published. Statistics should be disaggregated by factors such as age, gender and place of residence to ensure that any inequitable effect of the programs on specific groups can be monitored and corrected.¹²⁵

Depending upon financial capabilities and technology and knowledge availability, the precise practical application of the requirements of ICESCR on the right to health can vary from one state to another. In addition, the causes of ill-health differ from one country to another. Each state should determine its own priority health problems and decide which services are needed to address the problems.¹²⁶ This system should include appropriate indicators and benchmarks to make progressive realization possible. The national policy should include measures for producing a sufficient number of well-trained health workers, right-to-health impact assessments means, “bottom-up” participation in the policymaking process and accessible mechanisms of accountability.¹²⁷ According to the High Commissioner for Human Rights, the achievement of the highest attainable standard of physical and mental health requires the co-operation of several social, economic and health sectors. Key means for the full realization of the right to health are good governance, sound economic policies and well-founded democratic institutions that are responsive to people’s needs.¹²⁸

124 Ibid at para 55

125 General Comment no. 14 ICESCR, supra note 56, paras 36-37

126 World Health Organisation, supra note 55 at 8

127 General Comment no. 14 ICESCR, supra note 56, part 4

128 UN Commission on Human Rights, *Resolution no. 2004/27 on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2004) 4

Human rights, including the right to health, require the establishment of effective, transparent and accessible mechanisms of accountability. Accountability should not be used as a means for blaming and punishment but as a process to determine what in the system works (so that it can be repeated) and what does not (so that it can be adjusted). There are many forms of accountability, ranging from a free press to inquiries by national human rights institutions, court processing or administrative impact assessments. Within each state, there should be a range of accountability mechanisms. The form does not matter, as long as it is suitable for a country.¹²⁹ In some countries, the right to health has been given effect before domestic courts. Most successful court cases involved a right to certain healthcare services and environmental health, non-discrimination in access to rights in the private sector and arbitrary denial of access to healthcare and social benefits.¹³⁰ Discriminatory refusal of healthcare services is one of the cases that has received considerable attention by the CESCR.¹³¹ Without accountability, a state might use a shortage of resources as an excuse to do nothing or to respond primarily to the demands of interest groups with the “loudest voices”. Independent, effective and accessible mechanisms of accountability urge a state to explain its policies and actions toward the realization of the right to health for all.¹³² It should not be used as “window dressing”.

To successfully implement plans related to the right to health, everyone working in the fields of public health and medical care including community health workers, health professionals, policymakers, economists and administrators should be engaged in the health and human rights movement.¹³³ Human rights education and training should be integrated into all levels of the professional education system. National healthcare professional associations should enhance the awareness of their members about human rights and demand them to respect people’s rights. Everyone working in health-related sectors, including the staff of the ministries of health, should become familiar with the legal perspective of the right to health and its necessities in all health programs.¹³⁴ These days, the role of individuals in a healthcare system and health insurance is changing from passive consumers towards active participants claiming their rights.¹³⁵

129 UN Human Rights Council, supra note 88, at 13-15

130 Langford, M. ‘The Justiciability of Social Rights: from Practice to Theory’ in Langford, M. (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press, 2009) 17

131 Langford, M. King A. J. supra note 42, at 485

132 UN General Assembly, supra note 92, at 21

133 UN Commission on Human Rights, supra note 128, at 4

134 UN General Assembly supra note 92, at 14

135 Wildner, M, den Exter, A. P. van der Kraan, W. G. ‘The changing role of the individual in social health insurance systems’ in Saltman, B. R. Busse, R. Figueras, J. (eds) *Social health insurance systems in Western Europe* (European Observatory on Health Systems and Policies Series, Open University Press 2004) 248.

Patients' rights developments might increase the costs and threaten the solidarity and financial sustainability of healthcare system. It can be compensated for by empowering healthcare consumers to participate in decisions and by promoting accountability in the system.¹³⁶ people should be empowered at three levels: participation in national development by assertion of rights and representation, consultations on decision making and giving them freedom of choice, and involvement in treatment decisions, and administrative redress.¹³⁷ A change in individual responsibility is necessary when implementing healthcare reforms with a human rights approach. It will lead to better protection of individual rights and will preserve the sustainability of healthcare systems.¹³⁸

2.4 CONCLUSIONS

The above explanations of the nature and key aspects of health and the right to health at international level provide an insight into the realisation of this right and examination of a specific country case study in Part III. The right to health is a firmly established part of binding human rights law. Human rights treaties have clarified the scope and content of the right to health and translated the definition of health, provided by the WHO into operational policies and programs. The examples are General Comment no. 14 ICESCR on the right to the highest attainable standard of physical and mental health, and General Comment no. 15 of the Convention on the Rights of the Child (CRC) on children's right to health. According to these documents, State parties are required to use all necessary means including legislative and judicial measures for the realisation of this right. The next chapter establish a platform for analyzing the justiciability of this right at the international, regional and national levels.

136 den Exter, A. 'Purchasers as the public's agent' in Figueras, J. Robinson, R. Jakubowski, E. (eds) *Purchasing to improve health systems performance* (McGraw-Hill Education (UK) 2005)122-139

137 Wildner, M, den Exter, A. P. van der Kraan, W. G. supra note 135

138 Liu, Z. Buijsen, M. 'Reaffirming Individual Responsibility in Distributive Justice: A Case Study of the Chinese Healthcare System' [2017] *Int'l J. Soc. Sci. Stud.* 5, 14

Chapter 3

The Justiciability of the Right to Health in International Legal System

The Persian version of this part of the study was published in the Iranian Journal of Medical
Law 2016; 10(37): 7-33.

PART III

STATE PRACTICE: IRAN AS A CASE STUDY

INTRODUCTION

International human rights treaties require the state parties to realize the right of their populations to health by taking some steps and considering a set of principles. However, states retain a wide margin of discretion in selecting the measures for the realisation of this right. Obligations arising from the right to health are largely dependent upon national contexts and domestic conditions such as development level, and the political, demographic and socio-economic situations of countries. Moreover, events such as war and international economic sanctions adversely affect the socio-economic situation of people's lives and call for new policies for the protection of their rights. This part of the study first provides an introduction to Iran's socio-economic situation as well as its health system and laws in Chapter 4. It is followed by a comprehensive situational analysis of the right to health in Iran. Chapter 5 is about the effects of an important determinant of health- international economic sanctions on Iranians' right to health and the human rights obligations of Iran and the countries that imposed sanctions on this country. Studies on countries targeted by international economic sanctions show that sanctions have adversely affected the health of the population and their access to the necessities of life. One part of the study about the effects of the sanctions on the right to health in selected countries entitled 'Economic Sanctions as Determinants of Health' was published in the Shiraz E-Med Journal in 2017.¹ The other part of the study entitled 'Assessment of the Effects of Economic Sanctions on Iranians' Right to Health by Using Human Rights Impact Assessment Tool: A Systematic Review' was published by the International Journal of Health Policy and Management in 2018.²

The right to health is an inclusive right; it is a right to health facilities, services and products and to underlying determinants of health such as shelter, food and water. Moreover, the realisation of this right is dependent on other rights such as the rights to work and education and freedom from discrimination and violence. Therefore, a range of laws and policies in other sectors than health may affect this right. A requirement in the realization of the right to health is to consider this right in all development plans, laws and policies of states that might directly and indirectly affect health. Chapter 6 addresses the effects of a national development policy- new

1 Kokabisaghi, F. 'Economic Sanctions as Determinants of Health' [2017] Shiraz E-Med Journal 18(Suppl):e58662.

2 Kokabisaghi, F. 'Assessment of the Effects of Economic Sanctions on Iranians' Right to Health by Using Human Rights Impact Assessment Tool, a systematic review' [2018] International Journal of Health Policy and Management 7(5) 374-393

PART III

population policy of Iran on public health and people's right to health, specifically, their right to sexual and reproductive health. New population policies of Iran contain limitations on access to family planning services and contraceptives as well as incentives for having more children. In this chapter, the health and human rights aspects of the new policy are analysed and recommendations for protecting people's health and human rights are provided. The results of this part of the study were published in the *Journal of Public Health Policy* in 2017.³

3 Kokabisaghi, F. 'Right to sexual and reproductive health in new population policies of Iran' [2017] *Journal of Public Health Policy* 38(2) 240-256

Chapter 4

Right to Health in Iran

4.1 INTRODUCTION

The Islamic Republic of Iran is located in the Middle East. Tehran is the capital city; Persian is the official language and the Rial is the currency of Iran. The population of this country is about 80 million according to the 2017 census. In the following sections, the general specifications including history, geography, culture, demographics, structure of the government, and socio-economic situation of Iran are briefly explained. This part is followed by a review of Iran's health system, including its structure, legislation, and achievements and the health situation of different groups of the population.

4.2 GENERAL INFORMATION

4.2.1 History of Iran

Iran's history covers thousands of years. During the second millennium BC, Aryans, tribes of western and southern regions of the Siberia Plateau migrated to Iran. The name "Iran" comes from the ancient word "Aryanian" which means the land of Aryans. Iran's history has witnessed the fall and rise of many dynasties. In 600 BC, Cyrus, the Achaemenid king, defeated his rivals Medes, united Iran's people and made the Persian Region very vast. This region consisted of the Middle East, Central Asia and Pakistan. The next king, Darius (550 - 486 BC), expanded the military conquests of Cyrus. In the 4th Century BC, the Persian Empire, which had lasted for 200 years, collapsed with the invasion of Alexander. The rule of Alexander's successors was ended in the 2nd century BC by the Parthians who were of Iranian origin. At that time, the official religion of the Iranians was Zoroastrianism. The Parthian kingdom was ended after 350 years by the Sasanians in 224 AD. They ruled for almost 400 years until the Arab invasion of Iran. In the 7th century, early Muslims and disciples of Muhammad, the prophet of Islam, invited and forced Iranians to accept Islam. They were able to defeat the Sasanians in 651 AD and expanded Islam into Iran. Arab Muslims ruled Iran for two centuries. By the end of the Arab domination of Iran, this country had been the target of many invaders for 500 years. They destroyed most of the cities. In 1501, Shah Smail Safavi seized power, founded the Safavi dynasty and succeeded in establishing a central authority and improving Iran's development. Years after, during Nader Shah's reign (1736-1744) Iran had a powerful military force and the domination of Iran extended to India. After

the dissolution of the Afsharian dynasty, Karim Khan Zand established the Zand dynasty in 1751. Then, the Qajars took power in 1789 and established the Pahlavi dynasty which continued until 1979. In that year, through an Islamic Revolution, a new chapter in Iran's history started. The founder of the new political system and the first leader was Imam Khomeini. After his demise in 1989, Ayatollah Khamenei was chosen by the Assembly of Experts (a group of Islamic scholars).¹ Now, he is the highest authority in Iran.

4.2.2 Geographic Setting

Iran is the 16th largest country in the world with an area of 1.648.000 square kilometres. It shares land borders with 7 countries; Turkey, Iraq, Turkmenistan, Armenia, Azerbaijan, Afghanistan and Pakistan. The country has a diverse climate. In the northern part, it is mild and temperate; in the western part, it is Mediterranean; and in the southern part, it has semi-desert conditions. Over half of this country is mountainous, a quarter is desert and less than a quarter is arable land. Its climate is mostly semiarid or arid and sub-tropical along the Caspian coast. Iran is prone to frequent natural disasters including droughts, floods, earthquakes, and dust and sand storms. According to the WHO, Iran is ranked first in terms of the annual number of earthquakes with a magnitude of at least 5.5 on the Richter scale, relative vulnerability and the number of people killed in the earthquakes in the world.²

4.2.3 Political Structure and Government

The Islamic Republic of Iran was established following the Revolution of 1979. The Supreme Leader is the highest religious and political authority; he supervises the actions of all the state's branches. The Supreme Leader is appointed by the Assembly of Experts elected by people's vote. According to Article 110 of the Constitution, the Leader's functions and authority include the following:

1. Defining the general policies of the country after consultation with the State Expediency Council, and supervising the proper execution of policies.
2. Issuing decrees for national referenda and the declarations of war and peace, and mobilization of the armed forces.
3. Supreme command of the armed forces.
4. Appointing, dismissing, and accepting the resignations of the jurists of the Guardian Council, the Head of the Judiciary, the Head of the national radio and television network, the Chief of the Joint Staff (of armed forces),

1 Office of the UN High Commissioner for Human Rights, *Core Document Forming Part of the Reports of States Parties, Iran* (Geneva, Switzerland 1997) 1-3

2 World Health Organization, Regional Office for the Eastern Mediterranean, *Country Co-operation Strategy for WHO and Islamic Republic of Iran: 2010–2014* (WHO, Geneva 2010) 15-21

the Commander-in-Chief of the Islamic Revolution Guards Corps, the Commanders-in-Chief of the armed forces and the law-enforcement forces.

5. Resolving disputes between the three powers of the State, regulating their relations and resolving problems that are irresolvable by conventional means through the State Expediency Council.
6. Signing the President's appointment orders after his election by the people and dismissing the President, in consideration of the country's interests, after the Supreme Court finds him guilty of violating his constitutional duties, or following a vote of no confidence by the Islamic Parliament of Iran.
7. Pardoning or reducing, within the framework of Islamic criteria, of the sentences of convicts upon the proposal of the Head of the Judiciary.³

Under the authority of the Supreme Leader, power of the state of Iran is vested in three independent branches: legislative, executive, and judiciary. The president is the chief of the executive power and accountable to the Supreme Leader and the Parliament. The president is assigned by election for a four-year term. The Cabinet of Ministers is appointed by the president and approved by Parliament. Administratively, Iran is divided into 31 provinces that are run by Governor Generals appointed by the Ministry of the Interior and approved by the Cabinet of Ministers. Each province is divided into a number of districts that are governed by Governors appointed by the Ministry of Interior. There are 429 districts, each with several cities and villages. Iran has 1245 cities (each has more than 5000 inhabitants) and 69,000 villages. There are Provincial, City and Village Councils that decide on the development of their related areas.⁴ The Islamic Consultative Assembly (Parliament) is responsible for legislation. Parliament has 290 representatives chosen by the population. Laws passed by the parliament must be reviewed and approved by the Council of Guardians before implementation. This Council determines whether a proposed law is constitutional, and faithful to Islamic law. In the case of disagreement between the Council and Parliament, an expediency council that is appointed by the Supreme Leader has the final verdict.⁵ The Judiciary, according to the Constitution, is the protector of individual and social rights and is responsible for the promotion of justice. The responsibility of the Supreme Court is to supervise the correct implementation of the laws by the courts and to ensure uniformity of judicial procedures throughout the country.⁶

³ Iran's Constitution 1979, art 110

⁴ Statistical Centre of Iran, 'Country Divisions' (Statistical Centre of Iran 2016) <<https://www.amar.org.ir>> accessed 12 May 2017

⁵ World Health Organization, Regional Office for the Eastern Mediterranean, *supra* note 2, at 15

⁶ Iran's Constitution 1979, *supra* note 3, art 161

Chapter 5

Assessment of the Effects of International Economic Sanctions on Iranians' Rights to Health and an Adequate Standard of Living

This part of the study was published in the International Journal of Health Policy and Management 2018; 7(5): 374-393.

5.1 ABSTRACT

Over the years, international economic sanctions have contributed to violations of the right to health in target countries. Iran has been under comprehensive unilateral economic sanctions by groups of countries (not the United Nations) in recent years. They have been intensified from 2012 because of the international community's uncertainty about the peaceful purpose of Iran's nuclear program and inadequacy of trust-building actions of this country. This review aimed to identify the humanitarian effects of the sanctions on the right of Iranians to health and the human rights obligations of Iran and the international community.

To assess the effects of international economic sanction policies and to identify violated rights as well as the obligations of states according to international human rights laws in this study, the Human Rights Impact Assessments (HRIA) tool is used. Applying this tool requires collection of evidence regarding the situation of rights. To provide such evidence, a systematic review of literature which involved 55 papers retrieved from the electronic databases and official webpages of Iran's government and the United Nations' health and human rights committees and organizations was done. All articles about the consequences of economic sanctions related to the nuclear activities of Iran for the welfare and health of Iranians published from January 2012 to February 2017 in the English and Persian languages were included. Search terms were: economic sanctions, embargoes, Iran, welfare, health and medicine. Additional studies were identified by cross checking the reference lists of accessed articles. All selected papers were summarised and entered into a matrix describing study design and findings, and categorized into a framework of themes reflecting the areas covered (health and its underlying determinants). According to the HRIA framework, related obligations of Iran and other states about adverse effects of the sanctions on Iranians' right to health were extracted.

The sanctions on Iran caused a fall of the country's revenues, and the devaluation of national currency, and increased inflation and unemployment. These all resulted in the deterioration of people's overall welfare and reduced their ability to access the necessities of life such as nutritious food, healthcare and medicine. Also, the sanctions on banking, financial system and shipment led to a scarcity of quality life-saving medicines. The impact of sanctions was more severe on the lives of the poor, patients, women and children. Humanitarian exemptions did not protect Iranians from the adverse effects of sanctions.

Economic sanctions against Iran have violated Iranians' right to health. The international community should have predicted every probable humanitarian effect of sanctions and used every necessary means to prevent it. Furthermore, Iran should have used every essential means to protect people from the adverse effects of sanctions. Now, they should work on alleviation of the negative effects of sanctions. Even though some effects such as disability and death, due to inaccessibility of life-saving medicines cannot be compensated. In future, before imposition of sanctions, decisions makers should advance global plans to prevent such impacts on the populations of targeted countries.

Keywords: Economic sanctions; Embargoes; Right to health; Right to medicine; Human rights; Iran

5.2 INTRODUCTION

Since the First World War, sanctions have often been applied by international organizations and nations as a routine policy tool to react to any nation's actions that they oppose.¹ Economic sanctions seem at first to be more humane ways of resolving international disputes than wars. However, multiple studies on Iraq, former Yugoslavia, Nicaragua, Burundi, Cuba, and Haiti showed that due to their long term impacts on the lives and health of a large population, the adverse humanitarian effects of economic sanctions are comparable to, if not more severe than wars.² Through worsening the economic situation and functions of social systems of a target country, they decrease the access of people to the necessities of life such as nutritious food and medical care.³ From a practical point of view, there is no difference between dying due to being shot or being deprived of life-saving medicines. Iran has been targeted by economic sanctions for more than three decades. In this study, the effects of the sanctions on Iranians' right to health, as well as international human rights obligations of Iran and of the international community regarding this issue are analysed.

5.3 RIGHT TO HEALTH

According to the United Nations Declaration of Human Rights (1948), everyone has a right to an adequate standard of living adequate for his health and well-being including food, medical care and social security without any kind of discrimination on grounds of sex, race and the political, jurisdictional or international status of the place to which a person belongs.⁴ The right to health has been reflected in several international human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12. This right is a right to "the highest attainable standard of physical and mental health" based on ICESCR.⁵ Achievement

1 Avis, L. Engerman, S. 'History lessons: sanctions-neither war nor peace' [2003] *Journal of Economic Perspectives* 17(2) 187-197.

2 Allen, SH. Lektzian, DJ. 'Economic sanctions: A blunt instrument?' [2013] *Journal of Peace Research* 50 (1) 121-135; Garfield, R. Santana, S. 'The impact of the economic crisis and the US embargo on health in Cuba' [1997] *American Journal of Public Health* 87 (1) 15-20; Gibbons, E. Garfield, R. 'The impact of economic sanctions on health and human rights in Haiti 1991-1994' [1999] *American Journal of Public Health* 89 (10) 1499-1504; Peksen, D. 'Economic sanctions and human security: the public health effect of economic sanctions' [2011] *Foreign Policy Analysis* 7 (3) 237-251; Barry, M. 'Effect of the US embargo and economic decline on health in Cuba' [2000] *Annals of Internal Medicine* 132 (2) 151-154; Garfield R, Devin J, Fausey J. 'The health impact of economic sanctions' [1995] *Bulletin of the New York academy of medicine* 72 (2) 454.

3 Garfield, R. Santana, S. *supra* note 2; Gibbons, E. Garfield, R. *supra* note 2; Peksen, D. *supra* note 2; Garfield, R. Devin, J. Fausey, J. *supra* note 2

4 Universal Declaration of Human Rights 1948 art 25

5 International Covenant on Economic, Social and Cultural Rights 1966 art 12

of this level of health is one of the most important universal social goals. In the Constitution of WHO, the health of all human beings is defined as a necessary condition to the attainment of universal peace.⁶

According to ICESCR, the right to health includes a right to access timely and appropriate healthcare and the underlying determinants of health, such as safe water, nutritious food, housing, and a healthy environment. All the facilities, services and products related to health and its underlying determinants should be of good quality, acceptable, available and physically and financially accessible to all, without any kind of discrimination. States need to provide health insurance and financial aid for the poor to enjoy this right.⁷ The Committee on Economic, Social and Cultural Rights (CESCR) acknowledges resources limitations of states in realizing economic, social and cultural rights (ESCRs) in a limited time. Therefore, it requires states to fulfil minimum core obligations immediately after ratifying the covenant and to progressively realize these rights by taking steps and using the maximum available resources.⁸ The core obligations of the right to health include ensuring access to health facilities, services and products and minimum essential food, basic shelter, sanitation and safe water.⁹ While recognizing the possibility for states (which lack resources for providing the minimum of rights) to seek international assistance, the Committee requires all the states parties to realize the right to health and contribute to the improvement of international health.¹⁰

5.4 ECONOMIC SANCTIONS AND HUMAN RIGHTS

Sanctions are “measures taken by a state to coerce another to conform to an international agreement or norms of conduct, typically in the form of restrictions on trade”.¹¹ These measures are called countermeasures if they are resorted to against an international wrongdoer and are not decided upon the UN Security Council.¹² They may be comprehensive and prohibit commercial activities entirely with a country, or targeted (or smart) when they block transactions of and with certain businesses,

6 Constitution of the World Health Organisation 1948, Preamble

7 UN Committee on Economic Social and Cultural Rights. *General Comment no. 14 ICESCR: The Right to the Highest Attainable Standard of Health* (2000) para 12

8 International Covenant on Economic, Social and Cultural Rights, *supra* note 5 art 2

9 UN Committee on Economic Social and Cultural Rights. *General Comment no. 3 ICESCR: The Nature of States Parties' Obligations* (1990) para 10

10 International Covenant on Economic, Social and Cultural Rights, *supra* note 5 art 2

11 Simpson, JW. E. Oxford Dictionary online (2016) “sanction” <<http://www.oxforddictionaries.com/definition/english/sanction>> accessed 15 February 2016

12 Ronzitti, N. *Coercive Diplomacy, Sanctions and International Law* (Martinus Nijhoff Publishers, Leiden, Boston 2016) 1

groups, or individuals of a target country.¹³ According to Articles 39-43 of the Charter of the United Nations (1945), if the Security Council determines any threat to the peace, breach of the peace, or act of aggression, it can decide what measures shall be taken to maintain or restore international peace and security. These measures may include the use of armed forces, complete or partial interruption of economic relations and of rail, sea, air, postal, telegraphic, radio, and other means of communication, and the severance of diplomatic relations. All members of the United Nations are required to collaborate on these issues with the Council.¹⁴

In 2003, because the International Atomic Energy Agency (IAEA) was uncertain about the scope and nature of Iran's nuclear activities, it asked Iran to be transparent, build confidence and suspend all enrichment related and reprocessing activities including research and development. In 2006, the IAEA declared that it was "unable to make progress in its efforts to provide assurances about the absence of undeclared nuclear material and activities in Iran".¹⁵ Therefore, the case of Iran was brought to the UN Security Council. At first, Iran was required to be transparent and suspend its nuclear activities. However, Iran's trust building attempts were not adequate according to the UN Security Council. In 2007, Iran was confronted with the Council's sanction resolution related to its nuclear activities.¹⁶ All the sanctions defined by the Security Council against Iran were concerned with limiting its nuclear and military industry. No economic sanctions against this country were initiated by the Council.¹⁷ However, some countries decided to use "coercive diplomacy" and unilaterally boycotted Iran with economic sanctions in 2012. Concerning the measures to be taken by the members of UN in order to maintain international peace and security, the Charter of the UN clearly states that "the measures shall be concluded between the Security Council and Members or between the Security Council and groups of Members and shall be subject to ratification by the signatory states in accordance with their respective constitutional processes."¹⁸ General comment no. 8 of ICESCR about the relationship between economic sanctions and respect for economic, social and cultural rights indicates that:

Whatever the circumstances, such sanctions should always take full account of the provisions of the International Covenant on Economic, Social and Cultural Rights. The Committee does not in any way call into question the necessity for

13 Masters, M. 'What are economic sanctions?' (Council on Foreign Relations 2016) <<http://www.cfr.org/sanctions/economic-sanctions/p36259>> Accessed 25 March 2016

14 Charter of the United Nations 1945, art 39-43

15 Board of Governors of International Atomic Energy Agency. *Implementation of the NPT Safeguards Agreement in the Islamic Republic of Iran* (GOV/2006/27, 2006) para33

16 United Nations Security Council. *Sanction Resolution no. 1747* (2007).

17 United Nations Security Council. *Sanction Resolution no. 1929* (2010)

18 Charter of the United Nations 1945, supra note 14, art 43

the imposition of sanctions in appropriate cases in accordance with Chapter VII of the Charter of the United Nations or other applicable international law. But those provisions of the Charter that relate to human rights (Articles 1, 55 and 56) must still be considered to be fully applicable in such cases.¹⁹

Sanctions are called “brutal instruments” by the United Nations Food Program; the WHO has asked the international community to ban them altogether.²⁰ The Committee on the Rights of the Child also declared that economic sanctions can act as obstacles to the implementation of the Convention on the Rights of the Child (CRC).²¹ Through humanitarian exemptions for food and medicine, the sanctions are not usually designed to violate people’s right to health in target countries. But, still civilians of target countries suffer hardship, since it is not possible to separate the effects of economic sanctions on health and the general economy. The United Nations Human Rights Council declared in 2013 that there is reliable evidence about the serious consequences of sanctions on the rights of people, particularly vulnerable groups such as women, children, the elderly, the poor, minorities, indigenous people and persons living with disabilities.²²

Economic sanctions on countries such as Iraq, the former Yugoslavia, Nicaragua, Burundi, Cuba, and Haiti were associated with the deterioration of the health and welfare of the population.²³ In the sanctions period, a decline of revenues, the increase of poverty, unemployment, and inflation, as well as the deterioration of health services’ functions, school attendance and society’s development were reported. Also, the sanctions made essential goods more costly and difficult to produce and maintain.²⁴ In these situations, people’s ability to afford health services and maintain a healthy lifestyle has been reduced.²⁵ The rise of maternal, infant and child mortality rates has been considerable during the sanctions period in some countries. In addition, poor nutrition and the lack of access to health services and medical supplies brought severe public health problems such as epidemics particularly among the poor groups of society.²⁶ Furthermore, shortage of medicines and medical equipment damaged the practices of health systems. For instance, in Syria, sanctions limited

19 UN Committee on Economic Social and Cultural Rights. *General comment no. 8 ICESCR: The relationship between economic sanctions and respect for ESCRs*(2000) para 1

20 Maggie, O. ‘The Wake of War’. *Guardian*(Londen 1996) 2

21 United Nations. *Yearbook of the United Nations* (UN 1998) 1069

22 UN Human Rights Council. *Resolution no. 24/14 Human rights and unilateral coercive measures*(2013)para4

23 Garfield, R. Santana, S. supra note 2; Gibbons, E. Garfield, R. supra note 2; Garfield, R. Devin, J. Fausey, J. supra note 2

24 Garfield, R. Santana, S. supra note 2

25 Peksen, D. supra note 2

26 Garfield, R. ‘The impact of economic embargoes on the health of women and children’ [1997] *Journal of the American Medical Women’s Association* 52 (4)181-184

the import of essential medicines which were not produced locally.²⁷ Cuba also lost access to raw materials needed for manufacturing pharmaceuticals and lacked the currency to purchase medicines and medical equipment from the international market in the sanctions period.²⁸ Moreover, sanctions on the import of non-medical products and spare parts, and trade restriction on water and electrical supply systems reduced the effectiveness of health systems in Cuba, Iraq and Haiti, or trade embargoes on the agricultural sector such as limitation on the import of fertilizers and seeds caused food shortage.²⁹ In another case, the reduction of target countries' revenues has decreased the government's ability to finance the healthcare system. About Iran, sanctions on opening letters of credit for Iranian banks and the shipment of imported goods caused shortage of medicines. Therefore, it is clear that in order to ensure access of people to food and healthcare, the humanitarian exemptions and supplementary aid are not adequate.

5.5 SANCTIONS AGAINST IRAN

Poverty alleviation and social and health equity are prioritized in the Constitution and development plans of Iran. After the Revolution of 1979, a welfare state system which focuses on health, education and social aid has been established in Iran. As a result of a vast system of subsidies, material poverty has fallen significantly in this country. By improving urban infrastructure, providing electricity, safe water and sanitation facilities and universal free education, Iran has improved the living situation of Iranians to a great extent. In 2011, more than 95% of Iranians had access to improved drinking water sources and sanitation facilities. Total adult literacy rate was 85% in this year.³⁰ Also, for many years, Iran's government provided subsidized essential food stuffs such as flour, rice, cooking oil, sugar and milk to the entire population. In 2010, this country changed this policy to cash payment to everyone. Moreover, through establishing a successful primary healthcare network around the country, health outcomes have improved notably over recent decades. Life expectancy of Iranians increased from 63 to 73.3 during 1990-2012 and the rates of maternal, infant and child mortality fell considerably. Maternal mortality per 100,000 live births decreased from 91 to 24.6 and infant mortality per 1000 live births decreased

27 Sen, K. Al-Faisal, W. AlSaleh, Y. 'Syria: effects of conflict and sanctions on public health' [2012] *Journal of Public Health* 35 (2)195-199.

28 Barry, M. *supra* note 2

29 Peksen, D. *supra* note 2

30 United Nations Children's Fund (UNICEF). 'Statistics of Iran' (UNICEF 2017) <https://www.unicef.org/infoby-country/iran_statistics.html> accessed 12 May 2017

from 44 to 15 in this period. Communicable diseases have been controlled. They are no longer the major causes of mortality. Together, they cause less than 5% of annual deaths.³¹ The United Nations Children Fund (UNICEF) declared in 2011 that through a strong health and education network and infrastructure, Iran is on track to achieve most of the Millennium Development Goals including diminishing poverty and hunger, providing primary education, decreasing child mortality and improving maternal health.³² However, regarding the reduction of poverty, the country is facing major challenges such as an increase of people in need of support because of conditions including inflation and unemployment.³³

In recent decades, the people of Iran, having an oil-dependent economy and inefficient industry continuously faced numerous challenges including the effects of the Revolution of 1979, an eight-year-war with Iraq and several kinds of international sanctions affecting every sector from agriculture to the airline Industry. After the Revolution, the sanctions were mainly imposed by the United States of America (USA) and their effects were limited, since Iran could find ways to compensate for the loss partly through other countries or by some mediators with higher expenses. Sanctions imposed by the United Nations Security Council that aimed to force Iran to stop its nuclear activities targeted the military and the nuclear industry of Iran. However, without a mandate of the UN, the USA, the European Union and some other countries imposed comprehensive multilateral restrictions on any co-operation with Iran in foreign trade. Embargos of the USA include secondary sanctions on countries and companies doing business with Iran.³⁴

When international sanctions (imposed without a mandate of the UN) were intensified in 2012 to target all sectors of Iran's economy, the country's ability to sell oil became limited. As an oil-dependent country, Iran's revenues and financial ability to purchase needed supplies from the world market decreased considerably. It became worse after freezing the properties of Iran's Central Bank and other financial institutions in other countries. A sharp decline in oil revenues and industrial production, severe restrictions on the import of items, shipment and payment channels, and a strong devaluation of the national currency caused a high rate of inflation in

31 Ibid; World Health Organization, Regional Office for the Eastern Mediterranean, *Country Co-operation Strategy for WHO and Islamic Republic of Iran: 2010–2014* (WHO, Genova 2010) 30

32 United Nations Children's Fund. *Revised country programme document, Islamic Republic of Iran (2012-2016)* (UNICEF 2011) 2

33 World Health Organization, Regional Office for the Eastern Mediterranean, *supra* note 31, at 17-18

34 US Department of State. 'Iran Sanctions' (US Department of State 2016) <<http://www.state.gov/e/eb/tfs/spi/iran/index.htm>>accessed 12 May 2016; European Union. 'European Union Restrictive measures (sanctions) in force' (EU 2016) <https://europa.eu/european-union/index_en> Accessed 12 February 2016.

every sector of Iran's economy.³⁵ Also, Iran had to accept payment in gold, local currencies and bartered goods from a few Asian countries that still bought Iran's oil. Therefore, Iran's access to the dollar and the euro which are needed for imports from most countries became limited. Furthermore, sanctions cut off Iranian banks from the global financial system; international banks which dealt with Iran faced severe restrictions by the international community.³⁶ It made transferring of oil revenues back to the country very difficult. As a result, Iran had to process the transactions by intermediary banks that was extremely difficult and expensive.³⁷ These all diminished Iran's industry and economy and deteriorated Iranians' welfare considerably. GDP per Capita decreased by 35% during 2012 -2014 (chart no. 1).³⁸ The Consumer price index increased from 100 to 178 (chart no. 2) and the inflation rate increased from 20 to 38% during 2011-2013 (chart no. 3). GDP per Capita Purchasing Power Parity (PPP) decreased by more than 10% from 2011 until 2013 (Chart no. 4).³⁹ Minimum wage decreased from 275.4 US dollars in 2010 to 155 in 2012 (Table no. 1).⁴⁰ While the unemployment rate was 11.3 in 2016; this indicator was 10.5 in 2008.⁴¹

In this article, after introducing the methods of the study for assessing the humanitarian effects of sanctions and identifying materials that form the basis of the analysis, the adverse effects of economic sanctions on Iran's economy, the living conditions of Iranians and the situation of the rights to health and medicine are reviewed. Next, the practice and legal obligations of Iran's government and the international community in the process of sanctions' management are analysed. Finally, some recommendations for improving the enjoyment of Iranians of their rights to a standard of life and health are provided. Moreover, a couple of recommendations for future sanction regimes, in order to better respond to the humanitarian effects of the sanctions are given.

35 International Campaign for human rights in Iran. *A Growing Crisis; The Impact of Sanctions and Regime Policies on Iranians' Economic and Social Rights* (International Campaign for human rights in Iran 2013) 9-15

36 Namazi, S. *Sanctions and medical supply shortages in Iran; Viewpoints* (Wilson center, Washington 2013)20.

37 International Campaign for human rights in Iran. Supra note 35, at 9-15

38 World Bank. 'Statistics of Iran' (World Bank 2017) <<http://data.worldbank.org/country/iran-islamic-rep?view=chart>> accessed 15 May 2017

39 Trending Economics. 'Iran GDP per capita PPP' (Trending Economics 2017) <<https://tradingeconomics.com/iran/gdp-per-capita-ppp>> accessed 12 February 2017

40 Ramezani, A. 'Raise in minimum wage not enough for Iranian workers' (ALmonitor 2014) <<http://www.al-monitor.com/pulse/originals/2014/03/iran-wages-inflation-economy-law-protest.html>> accessed 12 May 2017

41 World Bank. 'World Development Indicators' (World Bank 2017) <<http://databank.worldbank.org/data/reports.aspx?source=2&series=SL.UEM.TOTL.ZS&country=>>> accessed 12 May 2017

5.6 METHODS

In this study, to assess the adverse effects of economic sanctions on people's right to health and to identify the national and international obligations related to this violation, the Human Rights Impact Assessments (HRIA) tool is used. To tackle the adverse impacts of trade agreements on the right to health, policy makers have employed various impact assessment tools such as the Sustainability Impact Assessment of EU Trade Agreements. However, traditionally these tools focus on economic and environmental and not social effects. HRIA is preferred because it uses a legally binding framework of international human rights law which is based on a strong normative consensus and universally agreed principles. Also, it evaluates a full range of international human rights, while it focuses on empowerment and improvement. The HRIA first emerged in the late 1990s for anticipating and measuring impact of policies and programs on different human rights. HRIA is helpful in identifying various types of duty- and right-bearers and their responsibilities. HRIA has been applied in a broad range of different fields such as development (by the Norwegian Agency for Development Co-operation and the US Food and Drug Organization (FAO)), health (by the UN Special Rapporteur of the Right to Health), trade (by the UN Bodies and national parliaments) and multi-national co-operation (by the UN Global Compact and the UN Human Rights Council).⁴²

HRIA is based on a legal framework of human rights and promotes accountability which is one of the key contributions of a human rights perspective.⁴³ The purpose of this tool is to identify any inconsistency between international human rights obligations and other national and international obligations. HRIA identifies human rights violations that can be taken to the judicial bodies, and ignoring them might cause significant legal consequences for violating states and institutions. In this assessment, human rights obligations are extracted from the main human rights laws such as the Universal Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966, General Comment no. 14 of ICESCR on the right to health and General Comment no. 8 ICESCR on the relationship between sanctions and the right to health. HRIA includes 8 steps for policy makers and 6 steps (as below) for scholars:

42 Baxewanos, F. Raza, W. *Human rights impact assessments as a new tool for development policy?* (Working Paper, Austrian Foundation for Development Research (ÖFSE) 2013) 7-8

43 Monash University Castan Centre for Human Rights Law. Prince of Wales International Business Leaders Forum. United Nations Office of the High Commissioner for Human Rights. *Human Rights Translated: A Business Reference Guide* (United Nations Publications 2008) Introduction

- 1) Screening: it requires selecting key human rights issues that are most likely to be affected. In this study, the screening is done through analysing the literature on the effects of economic sanctions on Iran and other countries.
- 2) Scoping: in this step, identifying the information needed, and formulating concrete questions are necessary.
- 3) Evidence Gathering: a quantitative as well as qualitative research techniques can be applied in this step. In this study, the content analysis of relevant papers has been done.
- 4) Consultation: it requires interviewing affected populations and other potential right-holders or using secondary material, such as reports, papers and experiences which provide primary data. In this study, a literature review about the effects of the sanctions policy on Iranians' lives is applied.
- 5) Analysis: in this step, by analysing the results of the literature review, the impact of the policy on specific human rights is concluded. In the case that sanctions negatively affected availability, accessibility, acceptability and quality of health (and of its underlying determinants) facilities, services, and products, it can be concluded that a violation of the right to health has occurred.
- 6) Conclusions and Recommendations: in this step, it is important to identify specific duty-bearers and assign them concrete responsibilities. (Figure no.1)⁴⁴

a) Search Strategy

The question of the study is: what are the implications of the economic sanction policies of 2012 (against Iran) on Iranians' right to health? A qualitative case study design involving a structured document review of relevant articles and policy documents was undertaken. Two sets of literature were studied; the first set was about the situation of Iranians' enjoyment of their right to health; while the second set was about the legal human rights obligations of Iran and the countries involved in the implementation of sanctions regarding Iranians' rights to health and a standard of living.

b) Selection Criteria

In order to determine keywords for search in databases, several articles about the subject were analysed. Collected documents included original articles, reviews, editorials, letters to the editors, interviews and short reports and communications. The papers that described the effects of economic sanctions on Iranians' right to health published from January 2012 until February 2017 were included. They were

44 Baxewanos, F. Raza, W. *supra* note 42

written in the English and Persian languages. Articles related to the effects of sanctions on other countries, sanctions which were not about Iran's nuclear program and non-economic sanctions were excluded. The papers related to the justification of sanctions against Iran were included in the study if they discussed the health effects of sanctions. Moreover, papers about sanctions related to Iran's human right violations were not considered.

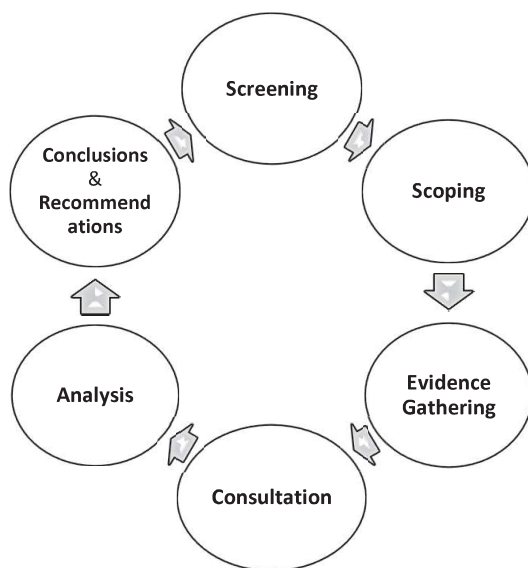


Figure 1. Human Rights Impact Assessments (HRIA) tool

c) Data Extraction

Data about the situation of Iranians' enjoyment of their right to health during the sanctions period were collected from electronic databases including EBESCO, PubMed, Web of Science, Scopus, Emerald, Elsevier, Cochrane library, Hein online, J Store, Project Muse, Science Direct Springer, Wiley Online Library, Oxford Journals, Embase, SID, and Google Scholar by searching keywords: "economic sanctions", "right to health", "healthcare", "embargoes", "medicine" and "Iran". More data was found by cross checking the reference lists of the accessed articles. Furthermore, the official webpages of Iran's government and the United Nations' health and human rights committees and organizations were studied to find the results of economic sanctions against Iran on people's right to health. The selection of papers was exhaustive to locate every available paper about the subject of the study. The collected papers were analysed in-depth in order to find evidence of humanitarian impacts of economic sanctions on Iranians' lives and their right to health. A total of 87 documents including papers (n=76), books (n=5) and reports (n=6) on the humanitarian effects of

economic sanctions were identified. The abstracts were reviewed, and duplicated articles, or those which were not pertinent to the study (because they were not about the effects of sanctions on health and its underlying determinants) or those which did not adequately address the impacts of sanctions on Iranians' livelihood and health (meaning that they did not clarify how the right to health is influenced) were put aside. 55 documents emerged to be related to the topic (Figure no. 2 PRISMA flow).

The other part of the study is about the obligations of targeted and targeting states about the right to health. For this part of the study, electronic databases including the United Nations Treaty Collections and the United Nations Official Document System were searched following the terms "human rights", "right to health", embargoes", "medicine" and "economic sanctions". The number of relevant international laws which were identified was 13. All selected documents were summarized and categorized in two main parts: the effects of sanctions on Iranians' right to health and the obligations of Iran and the international community about protection of Iranians' right to health.

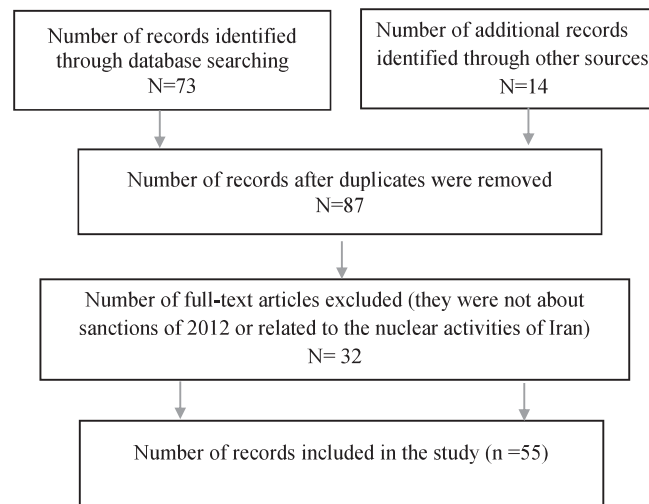


Figure 2. PRISMA flow

d) Data Analysis

Data gathering and analysis were organized according to the Human Rights Impact Assessments (HRIA) tool. All selected papers were summarised and entered into a matrix describing study designs and findings (see table no. 2). Findings were then categorized into a framework of themes reflecting the areas covered (health and its underlying determinants). The framework makes the structure of the review. The assessment was not quantitative; rather, it was simply heuristic to illustrate how

the right to health is affected by economic sanctions. Based on the findings, related obligations of Iran and other states about the effects of sanctions on Iranians' right to health were extracted. In the case of incompatibility of a certain policy with human rights obligations, HRIA suggests several options: the termination or amendment of the policy, the insertion of safeguards, and the adoption of compensation measures or other modification measures.⁴⁵

5.7 RESULTS

Economic sanctions have the potential to adversely affect the welfare and health of targeted populations. In the case of Iran, the results of the literature review indicated that the sanctions adversely affected affordability, accessibility and quality of health services and medicine and worsened the living standards of Iranians. In the next part of the article, these effects are explained. It is followed by the obligations of Iran and other countries about this issue.

Section 1) Iranians' Enjoyment of Their Rights in the Period of Sanctions

- *Effects of Economic Sanctions on Iranians' Standard of Living*

After releasing extensive reports by the media and the UN General Secretary about the humanitarian impacts of sanctions on Iranians' lives, particularly their access to food and medicine, the USA permitted its companies to sell selected medicines and medical supplies to Iran without requesting a licence from the Treasury's Office of Foreign Assets Control at the end of 2012.⁴⁶ Also, through the Joint Plan of Action, a channel for humanitarian support was established between Iran and six other countries in November 2013.⁴⁷ However, these exemptions of humanitarian trade did not guarantee access of Iranians to food, medicine and medical equipment. Since, limitations on trade, banking and financial system and shipment, made transferring of any goods including the exempted ones to Iran extremely difficult and expensive. The UNICEF described Iran in 2012 as a country under tightened unilateral sanctions which have adversely affected the environment, public health and socio-economic situation of ordinary people, especially children.⁴⁸ In the UN report on 5th October 2012, the General Secretary, Ban Ki Moon stated that "the sanctions

⁴⁵ Baxewanos, F. Raza, W. *supra* note 42

⁴⁶ George, MH, Z. 'Sanctions, government blamed for Iran's drugs shortage' (Reuters 2016) <<http://www.reuters.com/article/us-iran-medicine-idUSBRE8B40NM20121205>> accessed 15 June 2016

⁴⁷ E3/EU+3. *Joint Plan of Action regarding Iranian Nuclear Program* (2013) 3

⁴⁸ UNICEF. *Annual Report for Iran (MENA)* (UNICEF 2012) 1-2

imposed on Iran have had significant effects on the general population, including an escalation in inflation, a rise in commodities and energy costs, an increase in the rate of unemployment and a shortage of necessary items, including medicine {...} The sanctions also appear to be affecting humanitarian operations in the country {...} Even companies that have obtained the requisite licence to import food and medicine are facing difficulties in finding third-country banks to process transactions.”⁴⁹

Economic sanctions diminished Iran's economy considerably; from 2012 to 2014, GDP per capita fell dramatically by 35 % (chart no. 1).⁵⁰ While the value of the national currency declined by 80% during 2011-2013. In 2012, the overall inflation rate of the consumer price index was 36% and 41.4% respectively in urban and rural areas.⁵¹ Sanctions influenced all aspects of Iran's economy including public services that are necessary for the welfare of the population.⁵² They also contributed to an increase in the rates of inflation and unemployment (Chart no. 3).⁵³ The fall of Iran's revenues led to a decrease in the government's resources to pay its employees' salaries.⁵⁴ Almost all Iranian manufactures were hit by economic sanctions. Operating with partial capacity, they couldn't pay wages (which were below the poverty line) and had to lay off many workers; this worsened the living conditions of workers and their families considerably.⁵⁵ As a result, the purchasing power of the population decreased (Chart no. 3).⁵⁶ The minimum wage decreased by more than 50% from 2010 to 2012 (Table no. 1).⁵⁷

Sanctions influenced the socio-economic status of people, increased poverty, widened the income gap among different groups of Iranian society and decreased

49 Nichols, MC, L. 'General Secretary Ban Ki Moon, U.N. chief says sanctions on Iran affecting its people' (Reuters 2016) <<http://www.reuters.com/article/2012/10/05/us-iran-sanctions-un-idUSBRE89412Z20121005>> accessed 15 June 2016

50 World Bank, supra note 38

51 Plaut, S. 'the Collapse of Iran's Rial' (Gatestone Institute 2016) <<https://www.gatestoneinstitute.org/3597/iran-rial-collapse>> accessed 6 October 2016; World Bank. 'GDP per capita growth of Iran' (World Bank 2016) <<http://data.worldbank.org/indicator/NY.GDP.PCAP.KD.ZG?locations=IR>> accessed 8 November 2016

52 Gordon, J. 'Crippling Iran: the UN Security Council and the tactic of deliberate ambiguity' [2012] Georgetown Journal of International Law 44 (3) 973-1006

53 Ibid; Palaniappa, S. 'Sanctions Without Humanitarian Implications-An Impossible Feat' [2013] HIM 1990-2015. 1538.

54 Dizaji, SF. *The effects of oil shocks on government expenditures and government revenues nexus in Iran (as a developing oil-export based economy)* (ISS Working Paper Series/General Series 540, 2012) 1-41.

55 International Campaign for human rights in Iran, supra note 35, at 116

56 Trending Economics, supra note 39; Taghdisinejad, AS, A. 'The impact oil embargo on economic security of Iran' [2015] Journal of Management and defense research 13 (76) 1-32.

57 Ramezani, A. supra note 40

the welfare of the most vulnerable individuals and groups to a great extent.⁵⁸ It was estimated that about 11% of Iranians were below the absolute poverty line and 30% were under the relative poverty line in 2016.⁵⁹ In rural and urban areas, the population below relative poverty line was respectively 15% and 13% in 2012.⁶⁰ By limiting the revenues of the government, sanctions decreased the capabilities of Iran to support the poor.⁶¹ In 2013, the UN Special Rapporteur on the situation of human rights in Iran highlighted the dramatic effects of sanctions on Iranians' standard of living.⁶² Sanctions adversely affected people's lives and violated their rights to education, health and development.⁶³ The sharp decline in the value of Iran's currency and being dependent on the import of food and related industries, and a change of country's policy on subsidized food contributed to a sharp rise in the price of food. After a significant increase of the unemployment rate, more Iranians reduced household expenditures by consuming lower quality and quantity food.⁶⁴

Moreover, along with the deterioration of the economic situation of families, more children left school to work, and got married to lower the financial burden on the shoulders of their parents. In recent years, the number of working and street children has also increased remarkably. These children have limited access to health services and education.⁶⁵ According to the Statistics Centre of Iran, formal child marriage increased more than 20% during 2012-2014.⁶⁶ In the province of Isfahan,

58 Marzban, HO, A. 'The Impact of Economic Sanctions on Gross Domestic Production and Social Welfare in Iran: Generalized Stochastic Growth Model' [2015] *Economic Research* 20 (63) 37-69; Farzanegan, MR. Mohamadikhabbazan, M. Sadeghi, H. *Effect of oil sanctions on the macroeconomic and household welfare in Iran: New evidence from a CGE model* (Joint Discussion Paper Series in Economics Faculty of Business Administration and Economics, University of Marburg, No. 07-2015, 2015)7; Asadi-Pooya, AA. Tavana, B. Tavana, B. Emami, M. 'Drug adherence of patients with epilepsy in Iran: the effects of the international economic sanctions' [2016] *Acta Neurologica Belgica* 16 (2) 151-155; Kordzaeh, MK. 'Immorality and Illegality of Sanctions and Iranian Response' [2014] *Iranian Review of Foreign Affairs* 5 (1) 89-120.

59 Lilaz, S. '11% of Iranians are living under the absolute poverty line' (Eghtesad Online 2016) <<http://www.eghtesadonline.com>> accessed 8 February 2016

60 Presidential Institute of Education and Research on Management and Planning (IERMP). 'Poverty in Iran' (IERMP 2014) <<http://www.imps.ac.ir>> accessed 8 February 2016

61 Mousavi, SFJ, F. Mohammadi, O. 'Us Unilateral Sanctions Against Iran; Contradiction in Slogan and Conduct, Extreme Politisization of Human Rights' [2015] *Public Law* 16 (46) 23-103.

62 UN General Assembly. *Situation of human rights in the Islamic Republic of Iran* (Report A/68/503:2013) part VIII

63 Dizaji, SF. Supra note 54; Ebrahimi, M. Jalalian, A. Esfandiyari, L. 'The impacts of economic sanctions on human rights in countries of Iran and Iraq' [2015] *World Scientific News* 10 (2015) 12-26; Portela, C. 'Are European Union sanctions "targeted"?' [2016] *Cambridge Review of International Affairs* 29 (3) 912-929

64 Palaniappa, S. supra note 53; Mousavi, SFJ, F. Mohammadi, O. supra note 61; Shahabi, S. Fazlalizadeh, H. Stedman, J. Chuang, L. Sharifabrizi, A. Ram, R. 'The impact of international economic sanctions on cancer care in Iran' [2015] *Health Policy* 119 (10) 1309-1318; Nematollahi, ZF. S. Hoseynzade, M. Abolhasani, L. 'The consequences of targeted subsidies, exchange rate and foreign exchange constraints arising from the imposition of sanctions on wheat, flour and bread' [2016] *Agriculture economy* 10 (1) 97-114.

65 UNICEF, supra note 48, at 1-2; UN General Assembly, supra note 62, part VIII; UN Economic and Social Council. *Concluding observations on the second periodic report of Iran* (E/C.12/IRN/CO/2; 2013) para 19

66 Keshvari, Z. 'Child widows in Iran' (Seminar on Child Marriage, Tehran, Iran 2016)

the number of street children increased by 120% during 2015-2016.⁶⁷ There is no official data about the number of street children in Iran. Statistics provided by different institutions range from two to seven million street children. Based on the reports of the National Statistics Centre of Iran, 1.7 million children work in Iran.⁶⁸ It was estimated that this number was about 700 thousands in 2009.⁶⁹ This situation exposed children to violence, drug addiction, HIV infection and harmful work such as selling drugs. There are cases of child trafficking; even though it is considered a crime by the laws of Iran.⁷⁰

In the sanctions period, women faced more socio-economic hardships; the job security and opportunities for women decreased.⁷¹ The effects were more serious for women who were economically dependent on the family or were heads of their family.⁷² A considerable number of Iranian women are unemployed and economically dependent on their spouses and children; they are vulnerable to the country's economic decline. Particularly female heads of households face poverty more than other women and often can not afford nutritious food and healthcare.⁷³ In addition, Iran is facing a new phenomenon of street women and significant increase of addicted women and sex workers. Chronic poverty is one of the main reasons of entering the illegal market of sex work in Iran.⁷⁴ Furthermore, the decline in financial ability of working age people made the living situation of the elderly worse too. Old Iranians usually are financially dependent to their children; in recent years, the number of the homeless elderly has increased.⁷⁵

A high percentage of young Iranians, including educated ones, are unemployed and live in poverty. In 2015, 57% of unemployed people were from the age group 15-29. The unemployment ratio of this age group has increased by 2.6% comparing

67 Farshad, M. 'An increase of 120 percent in street children in Isfahan' (Tasnim News 2017) <<https://www.tasnim-news.com/fa/news/1396/03/19/1430639/>> accessed 5 February 2017

68 Panahi, S. 'Ambiguity in the statistics of child work and street children' (Jahane Sanat 2017) <<http://jahanesanat.ir/?newsid=19418>> accessed September 2017

69 Abbasi, A. 'Child work in Iran' [2009] Planning and Management 1 (1) 15-22.

70 Daneshvar. 'Selling infants in Tehran' (Fars News 2016) <<http://www.farsnews.com/newstext.php?nn=13940816000307>> accessed May 2016

71 Chenoy, MA. 'Gender and Human Rights Violations as structural part of Unilateral Coercive measures' (Seminar of Experts on Unilateral Coercive Measures. United Nations, Geneva: Human Rights Council; 2013)

72 Gordon, J. *supra* note 52

73 UN Secretary-General. *Situation of human rights in Iran (A/HRC/25/75;2014) para29*; Hajizadeh, M. Nghiem, HS. 'Hospital care in Iran: an examination of national health system performance' [2013] International Journal of Healthcare Management 6 (3) 201-210; Seyedfatemi, N. Rafii, F. Rezaei, M. Hezaveh, MS. 'Factors influencing the health promotion in Female-Headed Households: Golden Triangle of Money, Time and Energy' [2015] Journal of Knowledge & Health 10 (4) 13-22.

74 Karamouzian, M. Foroozanfar, Z. Ahmadi, A. Haghdooost, AA. Vogel, J. Zolala, F. 'How sex work becomes an option: Experiences of female sex workers in Kerman, Iran' [2016] Culture, Health & Sexuality 18 (1) 58-70.

75 UN General Assembly, *supra* note 62, part VIII

to 2014.⁷⁶ The rate of mental illnesses such as depression and stress is high among unemployed young people.⁷⁷ Depression specifically increased after intensifying sanctions against Iran and the deterioration of people's economic situation.⁷⁸ Furthermore, Iran is one of the biggest hosts of refugees and asylum seekers in the world. Most refugees in this country are from Afghanistan and Iraq. The sanctions negatively affected the lives of refugees in Iran, and the operational and humanitarian assistance costs of the UN.⁷⁹

- *The Impacts of Sanctions on Iranians' Right to Health*

The rights to healthcare and social security are guaranteed by Article 29 of Iran's Constitution. In recent years, Iran has provided free primary healthcare throughout the country and improved the quality and quantity of health services to a great extent. However, over the years, the financial accessibility of health services has continuously declined; while the health insurance system of Iran has not provided universal coverage yet. Most uninsured people are from the lowest income groups. Patients' share of healthcare expenditure was 52% of total health expenditure and 88% of private health expenditure in 2012. The government and insurance companies paid the rest.⁸⁰

In 2012, when the sanctions against Iran were intensified, the inflation rate in the health sector was 44.3% and 45.6% respectively in urban and rural areas.⁸¹ Insurance companies reacted to the inflation by decreasing their services. It increased the patients' share of health services and ended in the withdrawal of healthcare and more reliance on self-treatment. Several studies showed an increasing tendency of Iranians to self-medication. There have been warnings about the adverse effects of reliance on self-treatment in Iran.⁸² Still services of public health facilities were cheaper than private ones, but they were overcrowded, lacked enough medicines

76 Jondoghi, M. 'Unemployment during three presidential periods' (Mahr News 2017) <<http://www.mehrnews.com/news/3955759>> accessed 12 May 2017

77 Salehi-Isfahani, D. 'Iranian youth in times of economic crisis' [2011] *Iranian Studies* 44 (6) 789-806.

78 Sha'bani, M. Mahkoei, H. Ghorbani, E. 'Investigating Socio-economic Challenges of Iran During Sanctions' [2015] *The Open Access Journal of Resistive Economics* 3 (1) 18-37

79 UN Refugee Agency. 'UNHCR global appeal 2014-2015' (UNHCR 2016) <<http://www.unhcr.org/528a0a2fb.html>> accessed 8 May 2016

80 World Health Organization. 'Global Health Expenditure Database 2016' (WHO 2016) <<http://apps.who.int/nha/database/ViewData/Indicators/en>> accessed 8 May 2016

81 Iran Customs Administration. 'Annual statistics 2011-2012' (Iran Customs Administration 2016) <<http://www.tccim.ir/ImpExpStats.aspx?slcImpExp=Import&slcCountry=&sYear=1391&mode=doit>> accessed 8 May 2016

82 Peykar, ZM, A. 'Economic and Institutional Factors Affecting Self Curing and Self-medication in Shahrekord' [2015] *Journal of Health Breeze* 4 (4) 7-14; Tahergorabi, Z. Kiani, Z. Moodi, M. 'Epidemiological study of self-medication and its associated factors among visitors to Birjand pharmacies' [2016] *Journal of Birjand University of Medical Sciences* 23 (2) 158-169; Ershadpour, RZ. H. Kalani, N. 'Review of the reasons of self-medication among the people of Iran' [2015] *Navidno* 18 (60) 16-23.

and had long waiting lists. In response, a few well-off patients travelled to other countries to get healthcare. Some other patients, especially with terminal and incurable illnesses, withdrew from health services due to inability to pay.⁸³ Sanctions with a large economic effect on a target country (similar to Iran's case) can have severe public health consequences which are very similar to the effects of major military conflicts.⁸⁴ Sanctions on Iran had the potential to disrupt the government's subsidized healthcare.⁸⁵ Economic sanctions decreased the revenues of Iran's government and its ability to invest on health, education and social security.⁸⁶ In this situation, the government had to change its priorities and cut the budget of certain public services, such as supporting the poor.⁸⁷ Therefore, the people's share of health services costs increased which adversely affected the access of people to healthcare.⁸⁸ Low income groups were more vulnerable to the effects of the sanctions. The poor paid a larger proportion of their income for healthcare.⁸⁹ In 2013, Iran enacted a law to reform its health system; one part of this law requires the government to cover at least 90% of hospital services' costs by public funds.⁹⁰ But still every year 1% of the population fall below the poverty line due to the catastrophic health expenditures.⁹¹

By limiting access to the necessities of life, sanctions against Iran endangered public health particularly the health of mothers, children and the poor.⁹² Economic sanctions have had other impacts on the health of people in Iran too. For example, due to the ban on fuel trade and related production knowledge and technology, locally produced poorly refined fuel was substituted that had the main role in polluting

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- 83 International Institute for Peace, Justice and Human Rights. *The impact of sanction on Iranian People Healthcare* (Switzerland, International Institute for Peace, Justice and Human Rights 2013) 2-12; Health Deputy of Ministry of Health and Medical Education. *Report of Health Deputy* (Ministry of Health and Medical Education of Iran 2012) 2
- 84 Bastani, P. Dinarvand, R. SamadBeik, M. Pourmohammadi, K. 'Pharmaceutical strategic purchasing requirements in Iran: Price interventions and the related effective factors' [2016] *Journal of research in pharmacy practice* 5 (1) 35.
- 85 Zare, H. Trujillo, A.J. Leidman, E. Buttorff, C. 'Income elasticity of health expenditure in Iran' [2012] *Health Policy and Planning* czs 106.
- 86 Dizaji, SF.; Portela, C. Supra note 63
- 87 Kheirandish, M. Rashidian, A. Kebriaeezade, A. Cheraghali, AM. Soleymani, F. 'A review of pharmaceutical policies in response to economic crises and sanctions' [2015] *Journal of Research in Pharmacy Practice* 4(3) 115.
- 88 Ahmadi, AM. Meskarpour_ amiri, M. 'The public health effects of economic sanctions as a global concern in 21th century: Why economic sanction is a cruel strategy' [2015] *Journal of Health Policy and Sustainable Health* 2 (1) 145
- 89 Dizaji, SF. ; Portela, C. Supra note 63; Rezapour, A. Azar, FE. Aghdash, SA. Tanoomand, A. Ahmadzadeh, N. Asiabar, AS. 'Inequity in household's capacity to pay and health payments in Tehran-Iran-2013' [2015] *Medical journal of the Islamic Republic of Iran* 29:245.
- 90 Portela, C. Supra note 63; Directive on Budget Allocation for Health System Reform 2014, art 1
- 91 Jaarzade N. 'Hidden inequalities are increasing in Iranian society' (Mehr News 2016) <<http://www.mehrnews.com/news/3742159>> accessed 12 May 2016
- 92 Ahmadi, AM. Meskarpour_ amiri, M. supra note 88

the air all over the country.⁹³ Because of economic sanctions, production models changed from clean techniques to polluting ones and led to the more use of old technologies and air pollution.⁹⁴ About 45,000 deaths in one year and an increase of lung cancer incidences among children were reported to be linked to air pollution in Iran.⁹⁵ Another example is the ban on selling air-craft parts to Iran that resulted in unsafe flights and endangered the lives of people. The same happened to automobile industry equipment. The sanctions also might endanger the mental health of people because of continuous signals of threats and deteriorated living standards. Recently, the rates of mental diseases and drug addiction and the cases of suicide among Iranians have increased considerably. According to the report of Iran's Ministry of Health and Medical Education, the rate of mental diseases has increased by 4% in last four years. The suicide rate increased by 7.6% during 2012-2013.⁹⁶ Unemployment and financial distress are two main causes of mental illnesses in Iran.⁹⁷ A study in the province of Ghazvin showed that unemployment, inflation and inequality had a meaningful relation with suicide rates.⁹⁸ Another example is the impact of economic decline on drug addicts and their families. While the price of medicines for the treatment of drug addiction and drugs themselves increased, drug users tend to decrease spending on their family's life and use cheaper substances.⁹⁹ New substances are associated with high risk methods of use, such as injection, and high risk sexual practices and more acts of violence. They can have long term side effects on the body organs of the addicts.¹⁰⁰

The harmful effects of economic sanctions on health status can remain hidden for several years and become evident in a longer period. As an example, lack of financial resources caused by sanctions is known as an obstacle to achieving the goals of the

93 Mousavi, SFJ, F. Mohammadi, O. *supra* note 61; Roshan, NAM, Sh. Abbassi, M. 'The Impacts of Economic Sanctions on Sustainable Development: Focusing on Labor' [2015] *Cumhuriyet Science Journal* 36 (3) 3458-3476; Mashhadi, AR, M. 'The Effects of Imposed Sanctions against Iran on Environment, Energy & Technology Transfer in International Law' [2015] *Public Law* 16 (46) 103-123.

94 Mousavi, SFJ, F. Mohammadi, O. *supra* note 61

95 UNICEF, *supra* note 48, at 2

96 Fars News Agency. '23% mental disorders in Iran' (Fars News Agency 2013) <<http://www.parsnews.com>>accessed 5 May 2016; Shafaf. 'Suicide in Iran' (Shafaf 2014) <<http://www.shafaf.ir/fa/news/248795>> accessed 5 May 2016

97 White, WL. 'Congress 60: An addiction recovery community within the Islamic Republic of Iran' [2015] *Alcoholism Treatment Quarterly* 33 (3) 328-347.

98 Yaghubidoost, M. 'Frequency of suicide attempts and their effective factors in Qazvin province' (Msc Medicine, Ghazvin University of Medical Sciences 2017)

99 Haghdoost, AA. Mostafavi, E. Mirzazadeh, A. et al. 'Modelling of HIV/AIDS in Iran up to 2014' [2011] *Journal of AIDS and HIV Research* 3 (12) 231-239; Deilamizade, A. Esmizade, S. 'Economic sanctions against Iran, and drug use in Tehran: a 2013 pilot study' [2015] *Substance Use & Misuse* 50 (7) 859-868.

100 Shariati-rad, S. Maarefvand, M. Ekhtiari, H. 'Emergence of a methamphetamine crisis in Iran' [2013] *Drug and Alcohol Review* 32 (2) 223-224

Prevention and Control of Non-communicable Diseases Program in Iran.¹⁰¹ Sanctions can have more direct and immediate adverse effects on health by limiting the availability and accessibility of medicine. Medicine has been theoretically exempted from sanctions against Iran, but in practice, the access of patients to quality medicine became limited from 2012. The report of the UN Special Rapporteur on the situation of human rights in Iran (2013) indicated that “humanitarian safeguards in the form of exemptions for foodstuffs, medicines, chemicals for the production of medications and medical supplies are failing to meet their intended purpose. Reports indicate that financial sector sanctions effectively frustrate the purpose behind humanitarian exceptions. They also stress that the supply of advanced medicines, which treat the most serious illnesses, are particularly affected. Advanced medicines are produced primarily by firms based in Western countries and are subject to 20-year patents, rendering it impossible to substitute products from an alternative source.” The ineffectiveness of humanitarian safeguards is apparent in Iran.¹⁰²

- Effects of Sanctions on the Right to Medicine

The universal right to safe, effective and affordable medicine is a fundamental element of the right to health; states should consider this right in their international agreements.¹⁰³ By having a national generic policy, a network for the provision and distribution of medicine and an overarching pricing system for medicine around the country, Iran had a satisfactory level of access to medicine and medical instruments before comprehensive sanctions.¹⁰⁴ Depending to the type of services, insurance companies cover 70-90% of the retail price of medicines. Iran produces about 96% of all the medications of its pharmaceutical market in the terms of number and volume. But, the value of imported medicine is about 40% of whole market.¹⁰⁵

With the tightening of sanctions in 2012, the situation changed; the government faced difficulties in the provision of medicine; locally produced and imported medi-

101 Takian, A. Kazempour-Ardebili, S. ‘Diabetes dictating policy: an editorial commemorating world health day 2016’ [2016] *International Journal of Health Policy and Management* 5 (10) 571

102 UN General Assembly, *supra* note 62, part VIII

103 UN Human Rights Council. *Resolution 12/24 on access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (A/HRC/RES/12/24, 2009) 2

104 Kheirandish, M. Rashidian, A. Bigdeli, M. ‘A news media analysis of economic sanction effects on access to medicine in Iran’ [2015] *Journal of Research in Pharmacy Practice* 4(4)199; Kebriaeezadeh, A. Koopaei, NN. Abdollahiasl, A. Nikfar, S. Mohamadi, N. ‘Trend analysis of the pharmaceutical market in Iran 1997–2010; policy implications for developing countries’ [2013] *DARU Journal of Pharmaceutical Sciences* 21 (1) 52.

105 Hosseini, SA. ‘Impact of sanctions on procurement of medicine and medical devices in Iran; a technical response’ [2013] *Archives of Iranian Medicine* 16 (12) 736–738

cal equipment and medicines started to be scarce.¹⁰⁶ Medicines were not subject to sanctions, but limitations on licensing, purchase and shipment of goods to Iran made the import of medicines difficult. Iran is dependent on the import of pharmaceutical raw materials, and production and quality control technologies which were not exempted from the sanctions. Therefore, the sanctions crippled the domestic pharmaceutical industry and disrupted the production and quality of generic medicine.¹⁰⁷ International pharmaceutical companies (and banks) were reluctant to deal with Iran because of the potential threat of secondary sanctions and difficulties of receiving the payment.¹⁰⁸ Being cut off from the international banking network, Iran had to pay cash in advance that was very difficult, if not impossible, for mass imports of medicines. Moreover, a shortage of foreign currency and the decline of the country's currency value made medicines expensive.¹⁰⁹ In addition, the complex process of providing banking facilities to importers and the extremely lengthy process of importation caused a shortage of medicine. Therefore, the cheapest medicines such as contraception pills and simple medical instruments such as vaccines, sutures and endoscopy instruments were not available in 2012.¹¹⁰ These all indicate that the pharmaceutical system of Iran was not prepared for providing medicine in emergencies and unusual situations such as economic sanctions.¹¹¹

Following multilateral sanctions of 2012, the import of medicines and raw medical materials fell by 30-55%¹¹² and the average shortage of medicine from less than 30 reached 144 types.¹¹³ 44% of scarce medicines were classified as essential medicines (a minimum requirement for a functioning health system) by the WHO. A vast majority of these medicines were exempted from the sanctions.¹¹⁴ Access to nuclear

106 Palaniappa, S. *supra* note 53; Asadi-Pooya, AA. Tavana, B. Tavana, B. Emami, M. *supra* note 58; Menezes, WA. 'The effectiveness of international sanctions imposed on Iran and Cuba: a comparative study' [2016] *Revista Eletrônica de Direito Internacional* 19 (Jun) 431-466; Duttagupta, S. Yampolsky, D. Chowdhury, C. 'Economic sanctions and market access for pharmaceuticals: case studies with Russia, Cuba And Iran' [2015] *Value in Health* 18 (7) A569.

107 Moret, ES. 'Humanitarian impacts of economic sanctions on Iran and Syria' [2015] *European Security* 24 (1) 120-140; Iranian Society of Atherosclerosis. 'Acute shortages of essential medicines for chronic patients' (Fifteenth Congress of Cardiology, Iran 2013); Massoumi, RL. Koduri, S. 'Adverse effects of political sanctions on the health care system in Iran' [2015] *Journal of Global Health* 5 (2) 020302

108 Mohammadi, D. 'US-led economic sanctions strangle Iran's drug supply' [2013] *The Lancet* 381 (9863) 279.

109 Massoumi, RL. Koduri, S. *supra* note 107

110 Baradaran-Seyed, Z. Majdzadeh, R. 'Economic sanctions strangle Iranians' health, not just drug supply' [2013] *The Lancet* 381 (9878) 1626.

111 Hashemi-Meshkini, A. 'Making the Public Health and Industrial Objectives Balanced; the Big Challenge of Iran's Food and Drug Organization' [2014] *Iranian journal of public health* 43 (5) 693.

112 UN General Assembly, *supra* note 62, part VIII

113 Roshan, NAM, Sh. Abbassi, M. *supra* note 93

114 Setayesh, S. Mackey, TK. 'Addressing the impact of economic sanctions on Iranian drug shortages in the joint comprehensive plan of action: promoting access to medicines and health diplomacy' [2016] *Globalization and Health* 12 (1) 31.

medicines and radiotherapy pieces for the diagnoses and treatment of cancer were completely cut off, since they were in the list of sanctions due to the possibility of military usage.¹¹⁵ Several studies showed that access of about 6 million patients with life-threatening diseases such as asthma, thalassemia, haemophilia, chronic diseases, blood disorders, multiple sclerosis and HIV/AIDS to their medicines was limited.¹¹⁶ In addition, anti-rejection transplant medicines, and kidney dialysis instruments were scarce in 2013.¹¹⁷ Domestically produced replacements were scarce and not effective enough. Unavailability and unaffordability of medicines resulted in poor drug adherence.¹¹⁸ A number of deaths due to the lack of access to medicines were reported in 2012.¹¹⁹ Furthermore, the shortage of medicines reduced the ability of the health system to provide services even in emergencies; suspended operations were serious problems following sanctions in 2012.¹²⁰ Moreover, Iran does not produce drugs for eradicated diseases and raw materials for antibiotics that can threaten universal public health. For example, Iran could not produce the BCG vaccine until 2015. Moreover, shortages of medicines and medical equipment needed for diagnosis and treatment of some diseases might change the county's overall disease burden; the number of deaths by non-communicable diseases (including cancer, diabetes mellitus, congenital anomalies, and cardiovascular, digestive, skin and musculoskeletal diseases) has increased in recent years in Iran.¹²¹

To compensate for the 30-46% fall in medicines imported from the US and the EU during 2011-2012, Iran increased its purchase of medicine and medical equipment from countries that did not ban the oil trade with Iran. From 2012, the purchase of medicine from China and India increased respectively two and five times.¹²² However, the alternative medicines usually were of lower quality and had limited effectiveness than equivalents.¹²³ Moreover, medicines have to be registered, and their safety and effectiveness must be approved by Iran's Medicine and Food Or-

115 International Institute for Peace, Justice and Human Rights, *supra* note 83, at 4; Health Deputy of Ministry of Health and Medical Education. *Supra* note 83 at 2

116 Gorji, A. 'Sanctions against Iran: the impact on health services' [2014] *Iran J Public Health* 43 (3) 381-382.

117 Ghiasi, G. Rashidian, A. Kebriaeezadeh, A. Salamzadeh, J. 'The impact of the sanctions against Iran on availability to asthma medicines in Tehran' [2016] *Iranian Journal of Pharmaceutical Research* 15 (3) 567; Karimi, M. Haghpahan, S. 'The effects of economic sanctions on disease specific clinical outcomes of patients with thalassemia and hemophilia in Iran' [2015] *Health Policy* 119 (2) 239-243.

118 Asadi-Pooya, AA. Tavana, B. Tavana, B. Emami, M. *supra* note 58

119 Iranian Society of Atherosclerosis, *supra* note 107; Bozorgmehr. 'In Iran, sanctions take toll on the sick' (*Washingtonpost* 2016) <https://www.washingtonpost.com/world/middle_east/sanctions-take-toll-on-irans-sick/2012/09/04/ce07ee2c-f6b2-11e1-8253-3f495ae70650_story.html> accessed 6 May 2016

120 Karimi, M. Haghpahan, S. *supra* note 117

121 Roshan, NAM, Sh. Abbassi, M. *supra* note 93

122 Iran Customs Administration, *supra* note 81

123 Namazi, S. *supra* note 36, at 5; Massoumi, RL. Koduri, S. *supra* note 107

ganization to be allowed to be produced, imported and distributed in Iran.¹²⁴ This process takes several months. In response to the shortages, Iran allowed medicines which were approved by the FAO or European countries to be imported without the assessment and national approval. It resulted in major side-effects and the intolerance of patients' bodies to changes in a long term treatment.¹²⁵ On the other hand, due to the absence of an official supply in health facilities and pharmacies, smuggled medicines were increased in the local market of Iran. They were often out of date, of poor quality, contaminated, or spoiled by climate extremes, while they were sold at several times more than the official price. It was also difficult to know if they were counterfeit or real.¹²⁶ In 2013, after eye surgery, 22 patients had a serious infection in their eyes and were at risk of losing their vision because of using a non-standard ampoule.¹²⁷

Economic sanctions also made medicines financially inaccessible. The increase in the medicines' price was 50-75% during 2012.¹²⁸ The price of most medications had been reasonable until recent years in Iran. To guarantee patients' access, Iran provides a subsidy for selected medicines. Usually, the amount of subsidy is determined at the end of each year based on the estimation of the medicine's price and country's revenues in the coming year. The sharp fall in revenues and the value of currency was not predicted in 2012. After facing shortage, Iran allocated more currency for the import of medicines and could establish companies in neighbouring countries in order to use their banking system for purchasing medicine. Now, medicine is available; but still it is expensive for the treatment of some diseases. Medicine is not affordable for the poor people who are also not insured. In this condition, some health services such as dental care has become a privilege which is inaccessible to the working and middle classes of the population.¹²⁹

- *Human Rights Impact Assessment of Economic Sanctions against Iran*

The results of the literature review prove that economic sanctions against Iran have resulted in decreasing the enjoyment level of Iran's population of their economic and social rights, specifically the right to health and its underlying determinants. About 80% of the papers studied indicated that the sanctions adversely affected ac-

124 Health Ministry and Medical Education of Iran. *Health and Treatment* (Vol 1, Iran Institution, Tehran 2005)87-88

125 Namazi, S. *supra* note 36, at 1-7

126 Cheraghali, AM. 'Impacts of international sanctions on Iranian pharmaceutical market' [2013] DARU Journal of Pharmaceutical Science 21 (1) 64.

127 Young Correspondents Club. '22 patients of Razi hospital were victims of American sanctions' (Young Correspondents Club 2016) <<http://www.yjc.ir/fa/news/5147664/22>> accessed 5 May 2016

128 Gorji, A. *supra* note 116

129 Butler, D.' Iran hit by drug shortage: sanctions cause increasing shortfall in medicines and vaccines' [2013] Nature 504 (7478) 15-17

cess to health services and products. 63% of papers expressed inaccessibility and affordability of medicine during the sanctions period. Moreover, 56% of the papers showed that the sanctions negatively affected underlying determinants of health such as environmental health, employment and access to food. The sanctions on Iran caused a fall in the country's revenues, devaluation of the national currency, and increase of inflation and unemployment. These all resulted in the deterioration of people's overall welfare and lowered their ability to access the necessities of life such as nutritious food, healthcare and medicine. Also, sanctions on banking and financial systems and shipment led to the scarcity of quality life-saving medicines. The impacts of sanctions were greater on the lives of the poor, patients, women and children. According to the Human Rights Impact Assessment, economic sanctions against Iran as international policies have had detrimental humanitarian effects; therefore, they should be reconsidered. To limit the nuclear activities of Iran, other measures should be used instead that do not have such effects. While international peace should be preserved, human rights obligations should not be forgotten. Review of the international human rights obligations of Iran and the international community about Iranians' right to health is helpful in considering the compensation measures.

Section 2) States' Obligations in Sanctions Period

To protect people during the sanctions period, countries that are imposing sanctions, the international community and the target country, have human rights obligations. The fundamental part of these obligations is that everyone should enjoy his/her rights without discrimination of any kind.

- Targeted Country's Obligations in the Sanctions Period

The review of Iran's response to the sanctions indicates that this country was not prepared for the sanctions, delayed in responding to the shortages and could not manage the situation appropriately. Also, bureaucratic constraints, corruption and inefficient resource management contributed to the deterioration of people's enjoyment of their basic rights.¹³⁰ In the period between the announcement and implementation of the sanctions, Iran should have prepared a national policy with suitable measures to prevent people suffering from the adverse effects of sanctions and to ensure everyone enjoys his/her basic rights including the right to health. The failure to take appropriate steps towards progressive realization of the right to health and to enforce related laws is in contrast with international human rights obligations. Moreover, Iran should have prevented third parties including black market dealers, pharmacies and health facilities that provided unsafe medicines, as well as smugglers who sent

¹³⁰ Gordon, J. *supra* note 52; Moret, ES. *Supra* note 107

scarce medicine to the neighbouring countries from violation of people's rights. Failure to regulate third parties' activities is against the right to health.¹³¹

Countries targeted by sanctions should respect international peace and security and human rights to alleviate the humanitarian crisis.¹³² In the sanctions period, the government of the target country still has human rights obligations. Lack of access to nutritious food, primary healthcare, basic shelter and education indicates that the country has failed to discharge its obligations under ICESCR. The state is required to monitor the human rights situation and take maximum available resources to eliminate the suffering with low cost programs and international assistance and co-operation. Moreover, even in severe resource limitations, vulnerable groups of the population such as children and the poor should be protected. Non-compliance with the core obligations of the right to health (access to health facilities, products and services and minimum essential food, basic shelter, sanitation and safe water) cannot be justified in any circumstances.¹³³ The CRC also states that children are entitled to human rights; parents without enough means should be supported to provide an adequate standard of living for their children. Governments should prohibit child marriage, child trafficking, child work, violence against children and engagement of children in drug selling which occur more in the period of economic decline. The needs of child immigrants and asylum seekers should be taken into account too.¹³⁴

Generally, states are required to respect, protect and fulfil the right to health. They should ensure that everyone, without any kind of discrimination, enjoys this right. At all times, including the sanctions period, states are required to provide available, accessible, acceptable and good quality facilities, services and products related to health and its underlying determinants to everyone. In addition, they are required to use all necessary means and the maximum of their available resources and to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.¹³⁵ There is the possibility to seek international assistance for the realization of the right to health too.

- *The International Community's Obligations*

The international community has two kind of obligations about the right to health. First, in co-operation with international organizations, all countries are required to provide conditions at international and regional levels to ensure everyone enjoys the

131 General Comment no. 14 ICESCR, supra note 7, para 51

132 UN Commission for Human Rights. *Resolution 2000/1 on Human rights and humanitarian consequences of sanctions, including embargoes*(E/CN.4/SUB.2/RES/2000/1; 2000) 1

133 General Comment no. 14 ICESCR, supra note 7, paras 43-44

134 UN General Assembly. *Convention on the Rights of the Child* 1989 art 22 & 27

135 General Comment no. 14 ICESCR, supra note 7, para 33

right to the highest attainable standard of physical and mental health. They should help developing countries to progressively realize this right by the establishment of effective and integrated health systems with an adequate, affordable and reliable good quality supply of medicine.¹³⁶ Second, they should avoid the violation of this right and prevent third parties such as international organizations and groups of countries from violating this right.¹³⁷ According to the United Nations Charter (1945), the Security Council may decide what measures including sanctions should be employed to maintain or restore international peace and security.¹³⁸ Generally, economic sanctions which are imposed by some countries against the others are inconsistent with the Charter's basic principles of equality and dignity of every human being. Resolution no. 39/210 of the UN General Assembly (1984) states:

Developed countries should refrain from threatening or applying trade and financial restrictions, blockades, embargoes, and other economic sanctions, incompatible with the provisions of the Charter of the United Nations and in violation of undertakings contracted, multilaterally and bilaterally, against developing countries as a form of political and economic coercion that affects their political, economic, and social development.¹³⁹

The Vienna Declaration and Program of Action (1993) urges states to refrain from adopting any unilateral trade measure (particularly affecting developing countries) that hamper the full realization of fundamental human rights especially the rights to an adequate standard of living, food, medical care, housing and social services.¹⁴⁰ Adoption of laws interfering with the enjoyment of the right to health, failure to take into account the legal obligations related to this right in bilateral and multilateral agreements, and to regulate activities of third parties in order to prevent them from violating the right to health are violations of the right to health. Imposing embargos and other measures that restrict the supply of medicine and medical equipment of another state should be banned. The CESCR prohibits restriction on these goods as a tool for political and economic pressure. States should respect the enjoyment of the right to health in other countries by refraining from denying or limiting the access of people to healthcare and medicine. They should ensure that their international agreements do not adversely impact upon this right. The member states of international

¹³⁶ UN Commission on Human Rights. *Resolution 2002/31 the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2002) 1-2

¹³⁷ General Comment no. 14 ICESCR, *supra* note 7, para 39

¹³⁸ Charter of the United Nations, *supra* note 14, Chapter VII

¹³⁹ UN General Assembly. *Resolution no. 39/210 on Economic measures as a means of political and economic coercion against developing countries* (A/RES/39/210; 18 December 1984) 2

¹⁴⁰ UN General Assembly. *Vienna Declaration and Programme of Action* 1993, para 31

and regional financial institutions should consider protection of the right to health in their credit agreements and lending policies.¹⁴¹

States are responsible legally for their policies that violate the human rights of people beyond their borders and for the policies that support this action by third parties. According to paragraph 39 of General Comment no. 14 ICESCR, states are required to prevent third parties from violating the right to health in other countries by way of legal or political means, if they are able to.¹⁴² Countries that impose, maintain or implement the sanctions should immediately take steps to respond to suffering experienced by people in target countries.¹⁴³ It can be done by facilitating the delivery of the necessary items for life and health such as medicine, food and medical equipment. The targeting states should carefully assess the effects of their policies and international agreements on the health of people in the target country. Subsequently, they should adopt laws and policies to alleviate the negative impacts of their agreements.¹⁴⁴ A country's population should not be deprived of their basic ESCRs due to any accusation that their leaders have violated international peace and security norms.¹⁴⁵

The international community should respect the ESCRs of the targeted population. The UN bodies should observe the situation of human rights and implement humanitarian and human rights laws. Otherwise, the basic principles underpinning international law such as equality of all human beings will lose credibility. In addition, the Security Council should alleviate sanctions regimes in order to eliminate the humanitarian effects of sanctions on target populations and to ensure that they have access to food, medicine and other necessities of preserving health.¹⁴⁶ It seems that regulations on humanitarian exemptions are formulated imprecisely and are confusing; they lack standards and an impact monitoring system. Also, exempted goods and their distribution are poorly understood and interpreted, and the rapid supply of humanitarian supplies is blocked.¹⁴⁷ These all have major implications for the basic rights of the population of a target country.

141 General Comment no. 14 ICESCR, supra note 7, para 39

142 Ibid, para 39

143 General comment no. 8 ICESCR, supra note 19, para 11

144 UN Commission on Human Rights. *Resolution 2004/27 the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2004)

145 General comment no. 8 ICESCR, supra note 19, para 16

146 UN Commission for Human Rights, supra note 132, at 1

147 Garfield, R. Devin, J. Fausey, J. supra note 2; Sponeck, HG. 'Sanctions and Humanitarian Exemptions: A Practitioner's Commentary' [2002] *European Journal of International Law* 13 (1) 81-87.

5.8 DISCUSSION AND CONCLUSION

According to the results of HRIA, economic sanctions against Iran have resulted in the violation of Iranians' right to health. There is incompatibility between obligations derived from economic sanction agreements and human rights. In this case, HRIA suggests several options: termination or amendment of the policy, insertion of safeguards, and adoption of compensation measures. The main principle of this assessment is that no policy at national and international levels should breach international human rights laws. This tool, at first, suggests that such policies should be stopped. However, it does not mean that countries should not face any limitation if they threaten international peace, rather it means such policies should protect people's basic human rights too. The assumption behind economic sanctions is that economic pressure on the population of a country forces the government to reconsider its policies. The statement that economic sanctions do not target humanitarian goods seems incorrect when they aim to diminish the main source of a state's revenue. The level of the realization of human rights is dependent to the state's income level. Therefore, economic sanctions endanger the people's enjoyment of their right to health by decreasing the available resources of a country to be spent on the health of the population.

Despite the international community's statement that sanctions are directed at the government of Iran for its nuclear program, during the sanctions period, the enjoyment of Iranians of their fundamental rights has been dramatically decreased. The sanctions affected the health of Iranians in two ways; first by worsening their living conditions through a rise in inflation and unemployment, and a decline of households' income and access to adequate nutritious food and healthcare; then, by direct effect on the availability, accessibility and quality of life-saving medicines. Humanitarian exemptions which were decided after serious shortages did not protect the population from the adverse effects of sanctions. If the purpose of sanctions was to pressure Iran not to develop nuclear weapons, they should have been about materials and the technology related to this program and targeted decision-making elites, not ordinary people. In fact, it seems that the world has overlooked countries that actively have nuclear weapons without ratification of the Non-Proliferation of Nuclear Weapons Treaty.

According to international human rights laws, the right to health is substantially a justiciable right.¹⁴⁸ Imposing countries, the UN treaty bodies and Iran should be accountable about the humanitarian effects of sanctions on Iranians' lives. Iran could

¹⁴⁸ Kokabisaghi, F. 'Justiciability of the Right to Health in International Legal System'[2016]The Iranian Journal of Medical Law 10 (37) 33-37

not appropriately handle the humanitarian crisis caused by sanctions and maintain the level of basic rights. This country should have predicted the impacts of sanctions and planned for the protection of its population. But some consequences of the sanctions such as limitations in access to medicine (which were exempted from sanctions) were difficult to predict. It shows that laws on humanitarian exemptions solely do not protect the rights of people in targeted countries. On the other hand, almost all the countries around the world are committed, through joining the UN and ratifying human rights treaties, to respect human rights of everyone without any kind of discrimination. No international human rights treaty has questioned the equality of human beings in their inherent dignity and fundamental rights. It is against all these treaties to assume that the violation of people's rights in a country under the pressure of sanctions is acceptable.

Olivier De Schutter, the UN Special Rapporteur of the right to food in his report of 2011 stated that a state which uses its means of influence, such as its economic leverage to induce policies in another state's jurisdiction and undermines the targeted state's human rights obligations, is responsible for the violation of rights under international law.¹⁴⁹ Iran was not the first country that faced sanctions; therefore the adverse impacts of sanctions on this country were entirely predictable by the UN Security Council and imposing countries. In future, before the imposition of economic sanctions, the international community should use effective measures to protect the human rights of a target country's population. States should use every political and legal means to prevent the violation of the rights of these people by other countries or international organizations. International laws related to economic sanctions need improvement too. All the UN organs' resolutions about economic sanctions have similar content and their language is not deterrent enough. They are soft laws advising targeting and targeted countries to respect human rights. However, no accountability system is established for countries that do not conform to these laws. According to General Comment no. 14 ICESCR, effective judicial and appropriate remedies at national and international levels should be provided for people whose rights are violated.¹⁵⁰ In Iran's case, even after the dissemination of the reports of the Special Rapporteur on Human Rights and the UN General Secretary about the humanitarian effects of sanctions, the imposing countries were not required to lift sanctions. The UN as a "centre for harmonizing the actions of nations in the attainment of peace,"¹⁵¹ should take a clear position about bilateral sanctions imposed arbitrary by countries or groups of countries against another one.

149 De Schutter, O. *Report of the Special Rapporteur on the right to food to UN* (A/HRC/19/59/Add.5;2011) para2

150 General Comment no. 14 ICESCR, supra note 7, para 59

151 Charter of the United Nations, supra note 14, art 1

Moreover, in the case of Iran, humanitarian exemptions were decided too late, while the process of implementation was not clear. Before the imposition of sanctions, an international plan for the protection of people should be advised and international intermediate organizations, certain companies and financial institutions should be designated to facilitate the implementation of the exemption policy. Furthermore, the effects of sanctions should be continuously monitored; if basic human rights are adversely affected, the sanctions policies should be reviewed. Economic sanctions with the current way of implementation are collective punishment of the population of target countries and violations of human rights treaties. By putting pressure on the population of a country, other countries will not be safe too. The prevalence of diseases and internal conflicts in a country (resulted from economic sanctions) are threats to the international health and peace. People who find their rights violated in their countries seek asylum in other countries. Considering a human rights approach in foreign policies might be a better solution than economic sanctions for resolving international disputes.

The adverse consequences of economic sanctions will take a long time to be alleviated, if it is not impossible. The social impact of economic sanctions against Iran may extend beyond the sanctions period because the costs of imposing sanctions exceed the benefits of lifting sanctions. Moreover, lifting sanctions will not necessarily lead to improving the living standards and welfare of Iranians if this country does not invest more on the population. After improving access to medicine and allocating more funds to the health system, now, Iran needs to make considerable efforts to improve the living situation of people, especially the poor and children by using all necessary means and available resources. In addition, this country should consider new policies to protect civilians from the violation of their rights in similar situations. Imposing countries and the international community should be accountable about the results of their actions in other countries; they should help Iran by every appropriate necessary means to improve the enjoyment of Iranians of their human rights which have been affected by the sanctions.

5.9 TABLES AND CHARTS

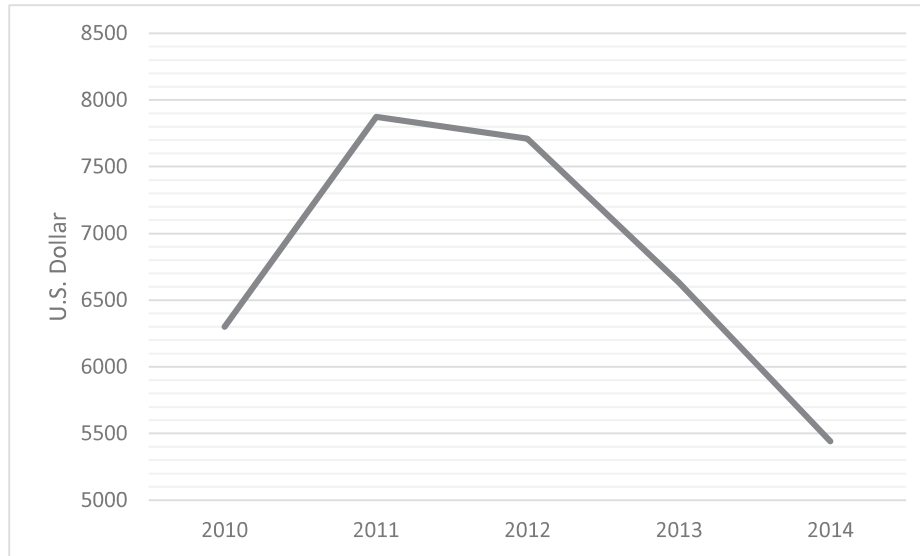


Chart 1. Iran's GDP per capita (US Dollar) during 2010-2014¹⁵²

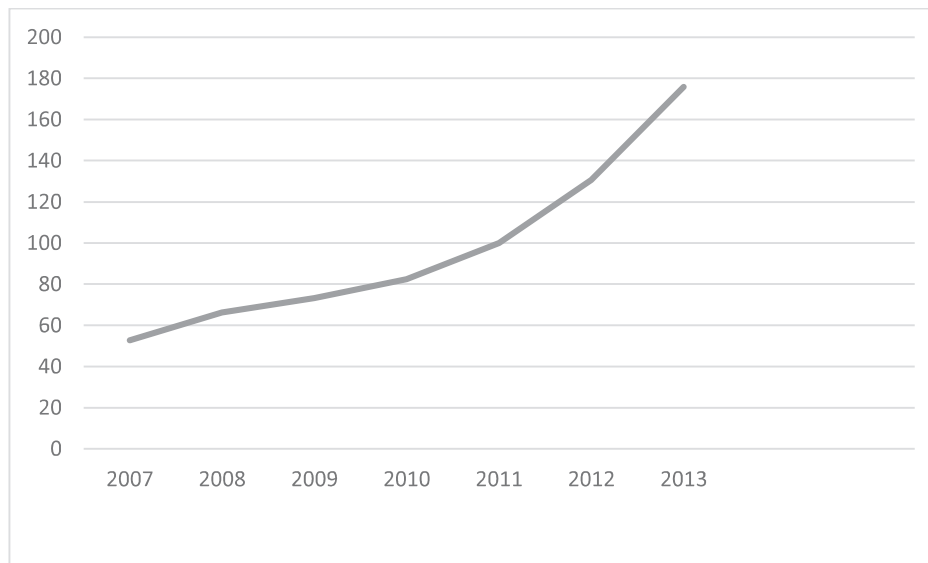


Chart 2. Iran's Consumer Price Index 2007-2013¹⁵³

¹⁵² World Bank. 'Iran's GDP per capita' (World Bank 2017) <<http://data.worldbank.org/country/iran-islamic-rep?view=chart>> accessed 9 February 2017

¹⁵³ Trading Economics. 'Consumer Price Index 2007-2013 Iran' (Trading Economics 2017) <<https://tradingeconomics.com/iran/consumer-price-index-cpi/forecast>> accessed 9 February 2017

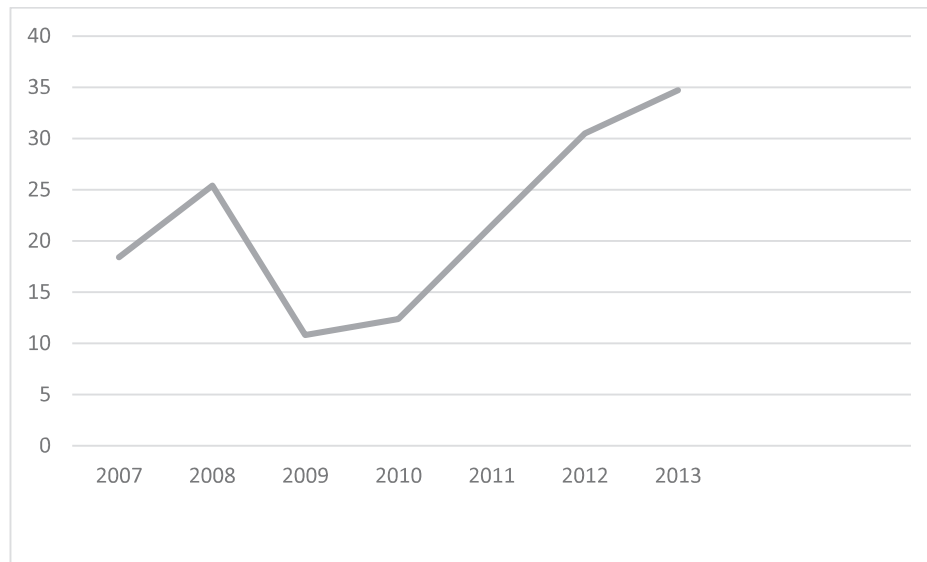


Chart 3. Iran's Inflation Ratio 2007-2013¹⁵⁴

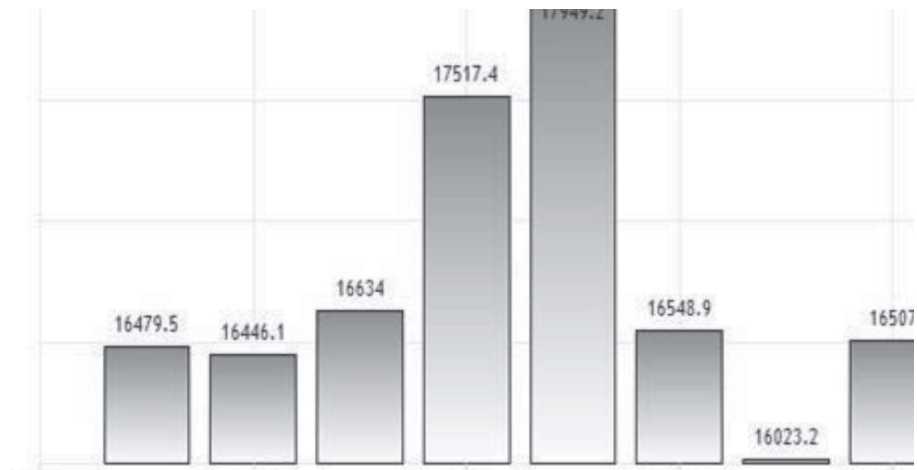


Chart 4. Iran's GDP per Capita Purchasing Power Parity (PPP) 2007-2014¹⁵⁵

154 Trading Economics. 'Infaltion Ratio 2007-2013 Iran' (Trading Economics 2017) <<https://tradingeconomics.com/iran/consumer-price-index-cpi/forecast>> accessed 9 February 2017

155 Trading Economics. 'Iran's GDP per Capita Purchasing Power Parity (PPP) 2007-2014' (Trading Economics 2017) <<https://tradingeconomics.com/iran/gdp-per-capita-ppp>> accessed 9 February 2017

Table 1) Minimum wage in Iran 2005-2014¹⁵⁶

Year	Minimum wage (\$)	Minimum wage based on free market rate(\$)	Annual rise compared to the previous year (%)	Inflation rate of year before (%)
2005	135.6	135.6	14	15.2
2006	162.6	162.2	18	10.4
2007	195.7	195.7	22	11.9
2008	227.3	227.3	17	18.4
2009	263.5	263.5	18	25.4
2010	275.4	275.4	13	10.8
2011	173.8	173.8	9	12.4
2012	155.8	111.3	18	21.5
2013	194.8	192.3	25	30.5
2014	243.5	202.9	25	36.7

¹⁵⁶ Al-monitor, 'minimum wage 2005-2014 Iran' (Al-monitor 2017) <<http://www.al-monitor.com/pulse/originals/2014/03/iran-wages-inflation-economy-law-protest.html>>accessed 9 February 2017

Table 2. Main findings of the literature review

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Determinants of health
1 Baradaran-Seyed, Z. & Majdzadeh, R. ¹	Review of the reports of Iranian Academy of Medical Sciences, Iranian Medical Council and the UN Secretary General	Sanctions against Iran's financial system made medicine inaccessible.	*	*
2 Butler, D. ²	Interviews with health professionals	Economic sanctions against Iran caused acute shortages of medicines, vaccines and key medical supplies. Humanitarian exemptions on food and medicine did not work.	*	*
3 Cheraghali, AM ³	Observations from Iran's pharmaceutical market	Sanctions on foreign trade, financial and banking services against Iran resulted in inaccessibility of lifesaving medicines and, weakened the national health sector and affected ordinary people.	*	*
4 Ghiasi G. et al. ⁴	Analysis of the collected data from a group of pharmacies	Imported and locally produced asthma medicines were not accessible in community pharmacies of Tehran during 2012-2013 in which sanctions against Iran were intensified.	*	*
5 Golzari SE. et al. ⁵	Observations of pharmaceutical market	Economic sanctions against Iran had led to shortages of patented and generic cancer drugs while this country has the highest incidence of cancer in the Middle East.	*	*

1 Baradaran-Seyed, Z. Majdzadeh, R. 'Economic sanctions strangle Iranians' health, not just drug supply' [2013] The Lancet 381 (9878) 1626.

2 Butler, D. 'Iran hit by drug shortage: sanctions cause increasing shortfall in medicines and vaccines' [2013] Nature 504 (7478) 15-17.

3 Cheraghali, AM. 'Impacts of international sanctions on Iranian pharmaceutical market' [2013] DARU Journal of Pharmaceutical Sciences 21 (1) 64.

4 Ghiasi, G. Rashidian, A. Kebriaeezadeh, A. Salamzadeh, J. 'The impact of the sanctions against Iran on availability to asthma medicines in Tehran' [2016] Iranian Journal of Pharmaceutical Research 15 (3) 567.

5 Golzari, SE. Ghabili, K. Khanli, HM. Tizro, P. Rikhtegar, R. 'Access to cancer medicine in Iran' [2013] The Lancet Oncology 14 (3) e87

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine Determinants of health
6 Gorji, A. ⁶	Observations of pharmaceutical market	Economic sanctions against Iran influenced all branches of Iranian economy and affected vulnerable patients. Unavailability of medicine and raw materials for domestic pharmaceutical companies, and medical equipment for hospitals, and unaffordability of medicines were big challenges of Iran during sanctions' period. The weakened medical infrastructure decreased the ability of the health system to provide services even in medical emergencies. Establishing uniform operational criterion and definitions for the exempted medicine and medical products for the future sanction regimes is necessary.	*	*
7 Hajizadeh M. & Nghiem, HS. ⁷	Investigating health system of Iran from financial, utilization, and quality perspectives	Quality of hospital care is different among different provinces of Iran. Economic sanctions seem to have negative impact on Iran's healthcare delivery system.	*	
8 Hosseini, SA. ⁸	Observation of pharmaceutical market of Iran	Because of sanctions on foreign trade, financial and banking services, Iran faced major difficulties in importing medicines and medical instruments. Quality, accessibility and affordability of medicines decreased during sanction's period. From a public health prospective, ordinary people and patients paid the cost of economic sanctions. Appropriate measures should be taken by the international community to facilitate access to medicine. To improve the process of medicine's importation, preparing a white list of Iranian pharmaceuticals companies and their foreign counterparts is necessary.		*

6 Gorji, A. 'Sanctions against Iran: the impact on health services' [2014] Iran J Public Health 43 (3) 381-382.

7 Hajizadeh, M. Nghiem, HS. 'Hospital care in Iran: an examination of national health system performance' [2013] International Journal of Healthcare Management 6 (3) 201-210.

8 Hosseini, SA. 'Impact of sanctions on procurement of medicine and medical devices in Iran: a technical response' [2013] Archives of Iranian Medicine 16 (12) 736-738.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Determinants of health
9 International Campaign for human rights in Iran ⁹	Review of scholarly material and journalistic accounts and interviews with a cross-section of Iranians	Economic sanctions against Iran and the country's policies resulted in a significant economic decline and deterioration of living standards of Iranians. Sanctions decreased the affordability and accessibility of healthcare and medicine.	*	*
10 International Institute for Peace, Justice and Human Rights ¹⁰	Interviews with health professionals, patients, health services managers and pharmacists	Sanctions on Iran have had destructive effects on healthcare system, and Iranians' lives and quality of life. Because of sanctions on banking system, import of medicines has become difficult. These are violations of people's basic human rights.	*	*
11 Karimi, H. & Haghpahan, S. ¹¹	Examining the effects of sanctions on access to healthcare from patients and physicians points of view	By adversely influencing accessibility of medicines, sanctions had considerable effects on public health and the health of patients with thalassemia and haemophilia.	*	*
12 Kheirandish, M. et al. ¹²	Media analysis	Negative effects of sanctions on access to medicines in Iran after the sanctions of 2012 is proved.	*	*
13 Mohammadi, D. ¹³	Interviews with clinicians	Economic sanctions against Iran affected the availability of essential and life-saving medicines. So patients had to seek their medicines from an unregulated black market.	*	*

9 International Campaign for Human Rights in Iran. *A Growing Crisis; The Impact of Sanctions and Regime Policies on Iranians' Economic and Social Rights*(International Campaign for human rights in Iran 2013) 9-15

10 International Institute for Peace, Justice and Human Rights. *The impact of sanction on Iranian People Healthcare* (Switzerland: International Institute for Peace, Justice and Human Rights 2013) 1-20

11 Karimi, M. Haghpahan, S. 'The effects of economic sanctions on disease specific clinical outcomes of patients with thalassemia and hemophilia in Iran' [2015] *Health Policy* 119 (2) 239-243.

12 Kheirandish, M. Rashidian, A. Bigdeli, M. 'A news media analysis of economic sanction effects on access to medicine in Iran' [2015] *Journal of Research in Pharmacy Practice* 4 (4) 199.

13 Mohammadi, D. 'US-led economic sanctions strangle Iran's drug supply' [2013] *The Lancet* 381 (9863) 279.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects		
			Healthcare	Medicine	Determinants of health
14 Moret, E. S. ¹⁴	Analyses of semi-structured interviews, official discourse and case studies	Economic sanctions negatively impacted the health of ordinary citizens in Iran and Syria through limiting the access to medicine and food.		*	*
15 Namazi, S. ¹⁵	In-depth interviews with Iranian importers, manufacturers, and distributors of pharmaceuticals and medical equipment as well as their Western counterparts	Economic sanctions against Iran have had severely affected the availability, accessibility and quality of medicines in Iran.		*	
16 Roshan, NA et al. ¹⁶	Review of literature on some health indicators before and during sanctions [*]	Economic sanctions have had negative effects on people's health particularly in the fields of medicine, and healthcare and environmental health.	*	*	
17 Setayesh, S. & Mackey, TK ¹⁷	Review of key characteristics of drug shortage in Iran	73 scarce medicines were closely tracked with the disease burden of the country. 44 % of these medicines were classified as essential medicines by the WHO. A vast majority of these medicines were exempted theoretically from the sanctions.		*	

14 Moret, ES. 'Humanitarian impacts of economic sanctions on Iran and Syria' [2015] *European Security* 24 (1) 120-140.

15 Namazi, S. *Sanctions and medical supply shortages in Iran; Viewpoints* (Wilson center, Washington 2013) 1-12

16 Roshan, NAM, Sh. Abbasi, M. 'The Impacts of Economic Sanctions on Sustainable Development: Focusing on Labor' [2015] *Cumhuriyet Science Journal* 36 (3) 3458-3476.

17 Setayesh, S. Mackey, TK. 'Addressing the impact of economic sanctions on Iranian drug shortages in the joint comprehensive plan of action: promoting access to medicines and health diplomacy' [2016] *Globalization and Health* 12 (1) 31.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Determinants of health
18 Shahabi, S. et al. ¹⁸	Literature review	Iran's National Cancer Control Program (NCCP) has substantial deficits, including a serious shortage of medicines for cancer care. Sanctions exempted medicines and food, but led to disruption of health services through making complications in the shipment of medicine or limiting access to foreign currencies for importing the medicine.	*	*
19 Iranian Society of Atherosclerosis ¹⁹	Observation of pharmaceutical market	There was an acute shortage of essential medicines for patients with cardiovascular disease in Iran in 2012.	*	*
20 Takian, A. & Kazempour-Ardebili, S. ²⁰	Review of Iranian National Action Plan for the Prevention and Control of NCDs and WHO framework	There are many obstacles hindering the achievement of the targets of the Iranian National Action Plan for the Prevention and Control of NCDs including the lack of financial resources. Economic sanctions exacerbated the situation. Safeguarding peoples' health and well-being in the post-sanctions era is necessary.	*	*
21 UN Economic and Social Council ²¹	Review of reports and observations	In recent years, the number of street and working children has increased. They have limited access to healthcare and education.	*	*
22 UN General Assembly ²²	Review of reports obtained from local newspapers and institutions such as the UNICEF and field observations	Sanctions adversely affected standard of living of Iranians particularly of children and elderly people. Medicine for the treatment of diseases such as cancer, heart disease, thalassemia, HIV/AIDS, haemophilia and multiple sclerosis were not accessible in 2012. Also, humanitarian exemptions for food, medicines and medical supplies could not meet their intended purpose.	*	*

18 Shahabi, S. Fazlalizadeh, H. Stedman, J. Chuang, L. Sharifabrizi, A. Ram, R. 'The impact of international economic sanctions on cancer treatment in Iran' [2015] Health Policy 119 (10) 1309-1318.

19 Iranian Society of Atherosclerosis. 'Acute shortages of essential medicines for chronic patients' (Fifteenth Congress of Cardiology, Tehran, Iran 2013)

20 Takian, A. Kazempour-Ardebili, S. 'Diabetes dictating policy: an editorial commemorating world health day 2016' [2016] International Journal of Health Policy and Management 5 (10) 571.

21 UN Economic and Social Council. Concluding observations on the second periodic report of Iran (E/C.12/IRN/CO/2; 2013) para 19.

22 UN General Assembly. *Situation of human rights in the Islamic Republic of Iran* (A/68/503; 2013) part VIII

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects		
			Healthcare	Medicine	Determinants of health
23 UN Refugee Agency ²³	Review of reports and observations	The sanctions adversely affected the life of refugees in Iran, and the operational and humanitarian assistance costs of UN.			*
24 UN Secretary-General ²⁴	Review of reports and observations	Unemployed women and female-headed families have been vulnerable to the country's economic decline of recent years in Iran. Since they are economically dependent, and more probable to face poverty.	*		*
25 UNICEF ²⁵	Review of reports and observations	Tightened unilateral sanctions against Iran have adversely affected the environment, public health and socio-economic determinants of health of ordinary people, especially children. In recent years, the number of working and street children has increased. These children have limited access to health services and education.	*		*
26 Zare, H. et al. ²⁶	Spline and quantile regression techniques	Income elasticity is lowest for the poorest Iranians living in urban and rural areas. Economic sanctions on Iran have the potential to disrupt government-subsidized healthcare services.	*		
27 Kebriaeezadeh, A. et al. ²⁷	Systematic literature review	Iranian pharmaceutical market has undergone a great growth. Before the sanctions, Iran's national pharmaceutical industry could provide essential medicines for patients.		*	
28 Hashemi-Meshkini, A. ¹¹¹	Literature review	Financial and trade sanctions revealed the weaknesses of Iran's domestic pharmaceutical industry in providing medicines and medical devices during political and international crisis.		*	

23 UN Refugee Agency. 'UNHCR global appeal 2014-2015' (UNHCR 2016) <<http://www.unhcr.org/528a0a2fb.html>> accessed 8 May 2016

24 UN Secretary-General. *Situation of human rights in Iran (A/HRC/25/75;2014) para29*

25 UNICEF. *Annual Report for Iran (MEN4)* (UNICEF 2012) 1-2

26 Zare, H. Trujillo, A.J. Leidman, E. Buttorff, C. 'Income elasticity of health expenditure in Iran' [2012] Health Policy and Planning (eys)106.

27 Kebriaeezadeh, A. Koopaei, N.N. Abdollahiasl, A. Nikfar, S. Mohamadi, N. 'Trend analysis of the pharmaceutical market in Iran 1997-2010; policy implications for developing countries' [2013] DARU journal of pharmaceutical Sciences 21 (1) 52.

28 Kheirandish, M. Rashidian, A. Kebriaeezade, A. Cheraghali, A.M. Soleymani, F. 'A review of pharmaceutical policies in response to economic crises and sanctions' [2015] Journal of Research in Pharmacy Practice 4 (3) 115.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine Determinants of health
29 Kheirandish et al. ²⁸	Review of reports and articles	Iran faced major challenges in the provision of adequate access to medicines during sanctions of 2010–2014. Economic crisis might lead to changes of national priorities for investment and expenditure and reduce government's available resources. Thus it may affect the health system and access to medicines.	*	*
30 Asadi-Pooya, A. et al. ²⁹	Retrospective chart review study of drug adherence of patients with epilepsy	Unavailability and unaffordability of medicines resulted in poor drug adherence. Shortage of medicines and increase of the price were directly associated with the intensifying of economic sanctions against Iran. These sanctions brought about considerable socio-economic hardships for Iranians.	*	*
31 Duttagupta, S. et al. ³⁰	Examining healthcare financing and market access implications of pharmaceuticals in light of the introduction or removal of sanctions.	Lifting economic sanctions on studied countries including Iran will have a positive impact on pharmaceuticals, from the perspectives of market access and technology transfer.	*	*

29 Asadi-Pooya, AA, Tavana, B, Tavana, B, Emami, M. 'Drug adherence of patients with epilepsy in Iran: the effects of the international economic sanctions' [2016] *Acta Neurologica Belgica* 116 (2) 151-155.

30 Duttagupta, S, Yampolsky, D, Chowdhury, C. 'Economic sanctions and market access for pharmaceuticals: case studies with Russia, Cuba And Iran' [2015] *Value in Health* 18 (7) A569

31 Deilamizade, A, Esmizade, S. 'Economic sanctions against Iran, and drug use in Tehran: a 2013 pilot study' [2015] *Substance Use & Misuse* 50 (7) 859-868.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine Determinants of health
32 Deilamizade, A. & Esmizade, S. ³¹	Interviews with drug users, questionnaires, participants' observations, and statistical analysis of the existing data	Because of economic sanctions, the price of goods and services including drugs has increased in Iran. Major changes in the drug use patterns and an increase in use-related harms of drugs are expected in near future.		*
33 Massoumi, R.L. & Koduri, S. ³²	Interviews with physicians and review of literature	Sanctions caused limitations in the import of medicines (pharmaceutical ingredients and finished products) and access to patented ones. The quality of substituted medicines was not satisfactory, while these scarce medicines were not affordable for some groups of patients.		*
34 Ahmadi, A. M. & Meskarpour_amiri, M. ³³	Review of literature	Study of target countries by sanctions including Iran showed that through limiting the access to minimum basic needs, economic sanctions can threaten public health especially the health of the mothers and children of poor families. Reduction of target countries' revenues can lead to reduction of government capacity to finance healthcare system and to increase of the share of households of healthcare costs and to adversely affect people's access to healthcare services.	*	

32 Massoumi, R.L. Koduri, S. 'Adverse effects of political sanctions on the healthcare system in Iran' [2015] Journal of Global Health 5 (2) 020302

33 Ahmadi, AM. Meskarpour_amiri, M. 'The public health effects of economic sanctions as a global concern in 21th century: Why economic sanction is a cruel strategy' [2015] Journal of Health Policy and Sustainable Health 2 (1).

34 Gordon, J. 'Crippling Iran: the UN Security Council and the tactic of deliberate ambiguity' [2012] Georgetown Journal of International Law 44 (3) 973-1006

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine Determinants of health
35 Gordon, J. ³⁴	Review of literature	Food security and access to healthcare and education were not supposed to be undermined by economic sanctions against Iran. The sanctions influenced every sector of Iran's economy and public services which were necessary for well-being of the whole population specifically poor women. Female heads of households faced much stress trying to feed their families, access medicines, and to buy necessary goods. In the sanctions period, unemployment and bankruptcies increased substantially.	*	*
36 Dizaji, SF. et al. ³⁵	Comprehensive set of vector autoregressive (VAR) models	Social impact of economic sanctions against Iran may extend beyond the sanctions period because the costs of imposing sanctions exceed the benefits of lifting sanctions.		*
37 Farzanegan, MR. et al. ³⁶	Examining the macroeconomic and household welfare consequences of oil sanctions in Iran by using social accounting matrix and developing a computable general equilibrium model	Iran's economy and households have been affected enormously by economic sanctions. The welfare of all income groups of urban and rural population has declined.		*

35 Dizaji, SF. van Bergeijk, PA. 'Potential early phase success and ultimate failure of economic sanctions: A VAR approach with an application to Iran' [2013] Journal of Peace Research 50 (6) 721-736.

36 Farzanegan, MR. Mohammadikhahbazan, M. Sadeghi, H. *Effect of oil sanctions on the macroeconomic and household welfare in Iran: New evidence from a CGE model* (Joint Discussion Paper Series in Economics Faculty of Business Administration and Economics, University of Marburg, No. 07-2015, 2015) 7

37 Kermani, MK. 'Immorality and Illegality of Sanctions and Iranian Response' [2014] Iranian Review of Foreign Affairs 5(1) 89-120

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects		
			Healthcare	Medicine	Determinants of health
38 Kermani, M. Kh. ³⁷	Conceptual framework of political economy	Sanctions adversely affected people's livelihood in Iran. It is ignoring basic human rights of Iranians particularly the rights to national development, life, health, and access medicine. Promoting justice by discriminatory punishment of innocent people is impossible.	*	*	*
39 Chenoy, MA. ³⁸	Review of reports and papers	Smart sanctions against Iran have severely impacted the socio-economic pattern of society and the lives of ordinary people. Inflation and shortages of food have led to high prices of food. The decline in women's status and, job security and opportunities coincides with sanction regime.			*
40 Rezapour, A. et al. ³⁹	Concentration Index on inequality	In recent years, out-of-pocket payment for healthcare increased while the capacity of households to pay for the services decreased. The poor spend a greater portion of their capacity-to-pay for healthcare, in comparison to the rich. Sanction-borne inflation in economic and health sectors has caused financial crisis. Supporting the poor and decreasing out-of-pocket must be considered in the future policies of Iran.	*		
41 Ebrahimi, M. et al. ⁴⁰	Literature review	Sanctions limited Iranians' enjoyment of their rights to an adequate standard of living, health, education and development.	*		*

38 Chenoy, MA. 'Gender and Human Rights Violations as structural part of Unilateral Coercive measures' (Seminar of Experts on Unilateral Coercive Measures. United Nations, Geneva: Human Rights Council; 2013)

39 Rezapour, A. Azar, FE. Aghdash, SA. Tanoomand, A. Ahmadvadeh, N. Asiabar, AS. 'Inequity in household's capacity to pay and health payments in Tehran-Iran-2013' [2015] Medical journal of the Islamic Republic of Iran 29:245.

40 Ebrahimi, M. Jalalian, A. Esfandyari, L. 'The impacts of economic sanctions on human rights in countries of Iran and Iraq' [2015] World Scientific News 10 (2015) 12-26

41 Menezes, WA. 'The effectiveness of international sanctions imposed on Iran and Cuba: a comparative study' [2016] Revista Eletrônica de Direito Internacional 19 (Jun) 431-466.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine
42 Menezes, WA. ⁴¹	Theoretical conceptual approach	Because of economic sanctions, health system of Iran faced difficulties in the import of medicines and medical equipment.		*
43 Neuenkirch, M. & Neumeier, F. ⁴²	Nearest neighbour matching approach	US sanctions have led to larger poverty gap in sanctioned countries including Iran compared to their nearest neighbours.		*
44 Palaniappa, S. ⁴³	Comparative study using literature review	Iran's health indicators used to be one of the best in the Middle East. The sanctions against Iran have had notable humanitarian implications, specifically on economic growth and health sector. The sanctions have decreased oil revenue and immensely destroyed economy of Iran. Unemployment, inflation, and commodity prices increased. They caused major shortages of medicine since the organizations with proper licenses were unable to find third-country banks for the import of medicine and food. Due to the rise in food costs and general inflation, many lower and middle class families could not afford food.	*	*
45 Sha'bani, M. et al. ⁴⁴	Content analysis of library resources and internet data	Socio-economic status of Iranians is influenced adversely by the sanctions in recent years. Iran is facing a great deal of different challenges such as unemployment, inflation depression, immigration to other countries, marriage problems, brain drain and economic downturn.		*

42 Neuenkirch, M. Neumeier, F. 'The impact of US sanctions on poverty' [2016] *Journal of Development Economics* 121: 110-119.

43 Palaniappa, S. 'Sanctions Without Humanitarian Implications-An Impossible Feat' [2013] *HIM* 1990-2015: 1538.

44 Sha'bani, M. Mahkoei, H. Ghorbani, E. 'Investigating Socio-economic Challenges of Iran During Sanctions' [2015] *The Open Access Journal of Resistive Economics* 3 (1) 18-37

45 Asadi, A. Shahrivar, MM. Esmaili, SM. 'Passing through sanctions by resistive economy' [2015] *The Open Access Journal of Resistive Economics* 3 (1) 50.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects		
			Healthcare	Medicine	Determinants of health
46 Asadi, A et al. ⁴⁵	Content analysis	Studying Iran showed that sanctions with a large economic effect on a target country can have severe public health consequences which are very similar to the effects of major military conflicts. Using resistive economy might be helpful to improve the situation.	*		
47 Bastani, P. et al. ⁴⁶	Content analysis with an inductive approach applying a five-stage framework analysis (familiarization, identifying a thematic framework, indexing, mapping, and interpretation)	Sanctions can influence the final price of domestic medicines, the production quality and the hidden prices of imported medicines. In order to improve access to medicine in Iran, affordability of medicines, effects of exchange rate fluctuations on the cost of pharmaceuticals, influence of sanction on the final prices of pharmaceuticals, efficiency, and patient's ability to co-operate in the payment should be taken into account.		*	
Portela, C. ⁴⁷	Analysis of the design of different categories of sanctions instruments	In Iran, sanctions affected the economy, healthcare and environment, and caused a decline in the living standards of the population. It made acquisition and distribution of medical and pharmaceutical supplies difficult while legislation exempted the importation of humanitarian items from sanctions. No plan for monitoring of impacts of sanctions on this country was devised.	*	*	*
48					

46 Bastani, P. Dinavand, R. SamadBeik, M. Pourmohammadi, K. 'Pharmaceutical strategic purchasing requirements in Iran: Price interventions and the related effective factors' [2016] *Journal of Research in Pharmacy Practice* 5 (1) 35.

47 Portela, C. 'Are European Union sanctions "targeted"? ' [2016] *Cambridge Review of International Affairs* 29(3) 912-929

48 Dizaji, SF. The effects of oil shocks on government expenditures and government revenues nexus in Iran (as a developing oil-export based economy) (ISS Working Paper Series/General Series 540, 2012) 1-41.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects	
			Healthcare	Medicine
49 Dizaji, SF. ⁴⁸	Impulse response functions and variance decomposition analysis	The decrease in Iran's revenues limited the government financial ability to finance healthcare, education and social security and to pay its employees' salary which damaged the Iranians' standard of living.	*	*
50 Taghdisinejad, A. & Allahmorad, S. ⁴⁹	Interviews with the elite using Delphi	Sanctions led to the increase of inflation, and decrease of government's revenues, public investment, employment, job security and stability, households' income and purchasing power and government's abilities to support vulnerable groups.		*
51 Nematollahi, ZF. et al. ⁵⁰	General equilibrium pattern	Economic sanctions against Iran and change of Iran's policy about subsidized food have increased food price and decreased the purchasing power of households, and food security.		*
52 Mostafavi, SM. et al. ⁵¹	Hsiao causality procedure	Economic sanctions led to the change of production models from clean techniques to pollutant ones and more use of old technologies and air pollution.		*
53 Mashhadi, A. & Rashdi, M. ⁵²	Literature review	Iranians' right to a healthy environment is violated by recent sanctions on the import of gasoline and energy sector, and limitation of access to related knowledge and technology.		*

49 Taghdisinejad, AS, A. 'The impact oil embargo on economic security of Iran' [2015] Journal of Management and Defense Research 13 (76) 1-32.

50 Keshvari, Z. '2000 child widows in Iran' (Seminar on Child Marriage/Iran News 2016) <<http://www.iran-newspaper.com/NewsPaper/BlockPrint/162159>> accessed 8 May 2016

51 Mostafavi, SM. Ghaemiasl, M. Hoseyni Ebrahimabad, S. A. 'Investigating the causality relationship among economic sanctions, Macroeconomic factors and environmental pollutants in Iran' [2014] Quantitative Economics 11 (1) 103-128.

52 Mashhadi, AR, M. 'The Effects of Imposed Sanctions against Iran on Environment, Energy & Technology Transfer in International Law' [2015] Public Law 16 (46) 103-123.

Table 2. Main findings of the literature review (continued)

Authors	Method	Relevant findings/message	Humanitarian effects		
			Healthcare	Medicine	Determinants of health
54 Mousavi, SF et al. ⁵³	Content analysis of international human rights laws and review of reports and literature	Sanctions against Iran influenced the livelihood of Iranians and resulted in more poverty and less welfare. Because of economic downturn, inflation, and decrease of households' purchasing power, some groups of the population cannot access the necessities of life such as food and shelter. Particularly the sanctions resulted in the violation of Iranians' right to health by adversely affecting accessibility of medicine and medical devices, increasing healthcare costs, decreasing government's financial ability to support the poor and limiting the import of quality gasoline.	*	*	*
55 Marzban, H. & Ostadzade, A. ⁵⁴	Extension of a generalized growth pattern despite a random exchange rate boycott	Since the economy of Iran is dependent to oil revenues, the sanctions resulted in the decrease of Iranians' welfare.			*
53 Mousavi, SFI, F. Mohammadi, O.	'Us Unilateral Sanctions Against Iran; Contradiction in Slogan and Conduct, Extreme Politization of Human Rights' [2015] Public Law 16 (46) 23-103.				
54 Marzban, HO, A.	'The Impact of Economic Sanctions on Gross Domestic Production and Social Welfare in Iran: Generalized Stochastic Growth Model' [2015] Economic Research 20 (63) 37-69.				

Chapter 6

The Right to Sexual and Reproductive Health in New Population Policies of Iran

This part of the study was published in the Journal of Public Health Policy 2017; 38(2): 240-256.

6.1 ABSTRACT

Sexual and reproductive health services in Iran are influenced by population policies. The willingness of Iranian policy makers to control the population's growth resulted in the provision of countrywide family planning services and contraceptives from 1990 to 2013. Now policy makers favour population growth because of a statistically significant decline in the fertility rate and ageing of the population. New population policies contain incentives for higher fertility and limitations on family planning services. Some elements of these policies contradict standards of international human rights treaties including the prohibition of retrogressive measures and limitations on sexual and reproductive health services. These policies may jeopardize individual and public health. Iran should immediately revoke these laws and policies and progressively improve people's enjoyment of their right to sexual and reproductive health. The country's population policies should focus on encouraging people to have higher fertility by providing financial and social support to parents and future children.

Keywords: Right to sexual and reproductive health; Public health; Population policy; Right to health; Iran

PART IV

VULNERABLE GROUPS AND THE RIGHT TO
HEALTH IN IRAN

INTRODUCTION

Some individuals and groups, such as poor women, children, the disabled, refugees, the indigenous and minorities might lack essential means for exercising or enjoying their rights as others do. According to the ICESCR and its General Comment no. 14 on the right to health, state parties to the ICESCR are required to provide the necessary means for promoting equality and justice in the enjoyment of the right to health and its underlying determinants.¹ In previous chapters, the situation of the right to health in Iran was analysed. The chapters include a review of the health system structure and laws, and the health status and situation of access to health facilities, services and products and a brief explanation on the vulnerable groups of population. The effects of international economic sanctions and national population policies on Iranians' right to health were analysed too.

At international level, to protect the rights of some groups of populations, especial treaties such as the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women were adopted. They include several General Comments for the protection of the right to health. The health of women and children is important for public health. In this part of the study, the situation of two groups of Iranian population, women and children in the enjoyment of the right to health is analysed. The discussion is about the current situation of the right to health and the adequacy of related laws and policies to guarantee the access of women and children to health facilities, services and products. Two issues were addressed about women: first, the situation of the right to health and access of women to healthcare in Iran. The framework of non-discrimination, affordability, physical accessibility and information accessibility was used for the analysis. (this part of the study is published in the International Journal of Health Planning and Management in 2019.) The second issue is the role of male guardians in women's access to health services in this country. This part of the study was published in the International Journal of Law, Policy and the Family in 2018.²

With respect to children, the access of different groups of children, including the refugee, the poor, street children, and children without identity, children living with a disability, young children and adolescents, and the related national and international

1 UN Committee on Economic, Social and Cultural Rights, *General Comment no 14 ICESCR on the Right to Health* (2000) para30-33

2 Kokabisaghi, F. 'The Role of Male Guardian in Women's Access to Health Services in Iran' [2018] International Journal of Law, Policy and the Family 32(2)230-249

PART IV

human rights treaties were analysed and some recommendations to improve the living standards and access of children to healthcare facilities and services were given. The results were published in the *Journal of Medicine and Law* in 2017.³

Some parts of the next chapters might overlap with previous chapters because there are issues which should be taken into account in analysing the situation of the rights of different groups of population. Most of these chapters were published as articles in peer reviewed journals so they are presented as they were published and can thus be read independently.

3 Kokabisaghi, F. 'Equity in Access to Healthcare for Children: Domestic Implementation of the International Human Rights Law in Iran' [2017] *Medicine and Law* 36(2) 59-80.

Chapter 7

Women's Right to Health in Iran: Domestic Implementation of International Human Rights Law

This part of the study was published in the International Journal of Health Planning and Management 2019(first online);<https://doi.org/10.1002/hpm.2737>

7.1 ABSTRACT

In Iran, discrimination based on gender in the enjoyment of the right to health is prohibited. Making health services physically and financially accessible to entire population and removing social and cultural barriers of women's access to health services are main considerations of the health laws and policies of Iran. The health of Iranian women has improved considerably in recent years. But there are disparities in the health status, and access of women to health services around the country. Some groups of women, including the poor, the elderly, the disabled, the illegal immigrant, and those without an appropriate male guardian, and rural women have limited access to health services in Iran. To realize women's right to health, this country should immediately remove the disparities and use all necessary means including legislative, administrative, budgetary, promotional and judicial measures. National plans on women's empowerment and support should be interpreted in provincial programs and action plans. Moreover, a monitoring system and certain benchmarks for tracing the progress of the plans should be established. Realizing other economic, social and cultural rights including the rights to food, shelter, education, work, social security and participation in society will improve the Iranian women's enjoyment of their right to health.

Keywords: Women; Right to health; Iran; Human rights; Women's health; Women's rights

7.2 INTRODUCTION

The Right to health has been recognized by several international human rights treaties such as the Universal Declaration of Human Rights (UDHR) 1945 and the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966. According to the UDHR, everyone has a “right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.¹ Article 12 of the ICESCR defines the right to health as “a right to the enjoyment of the highest attainable standard of physical and mental health.” Any discrimination on any prohibited grounds such as race, sex, language, national or social origin and religion in the exercise of this right is prohibited.² However, around the world, women face more obstacles to access health services than men. They often have less power in making decisions in their families and about their health and lives. Furthermore, they are more likely to be poor, unemployed and economically dependent on men.³ Therefore, women’s right to health and equal access to health services should get especial attention in national and international health policies.

Equality of men and women in the enjoyment of their human rights including the right to health does not mean that any difference is not admitted at all. Being a man or women should not be regarded as an advantage in access to healthcare. Socio-cultural and biological factors influencing the health of men and women are different and that may necessitate special care for women, for example during pregnancy. National health policies should have a gender-based approach.⁴ The strategies for the promotion of women’s health should include the prevention and treatment of women’s diseases, reducing risks to women’s health, lowering maternal mortality rate, protecting women from domestic violence and harmful traditional practices, and removing all the barriers to women’s access to health services and information.⁵ According to General Comment no. 14 of ICESCR, the accessibility of healthcare

1 Universal Declaration of Human Rights 1948 art 1-2.

2 International Covenant on Economic, Social and Cultural Rights 1966 art 12.

3 Office of the United Nations High Commissioner for Human Rights and World Health Organization. *The Right to Health, Factsheet no. 31* (Geneva, United Nations 2008) 12

4 World Health Organization, *25 Questions and Answers on Health and Human Rights* (World Health Organization: Switzerland 2002)13

5 United Nations Committee on Economic, Social and Cultural Rights. *General Comment no. 14 ICESCR: The Right to the Highest Attainable Standard of Health* (2000)

services has four overlapping dimensions; non-discrimination, physical accessibility, affordability and information accessibility.⁶

Iran has ratified the ICESCR and several other international human rights treaties which recognize the equality of men and women in their fundamental rights; but it has not ratified the Convention on the Elimination of all Forms of Discrimination against Women. Some provisions of this convention, such as the equality of men and women in marital rights, inheritance, age of legal responsibility and the nationality of their children, are in conflict with the country's laws. However, the conflict is not about women's right to health, and Iran does have obligations regarding women's right to health based on other accepted human rights treaties. In this country, there are several vulnerable groups of women such as poor women, female heads of families, the indigenous and women without a male guardian. They frequently face difficulties accessing health services. Based on the studies of Karyani and et al. (2015), Haghdust and et al. (2011) and Mostafavi and et al. (2015), women do not have equal access to gynaecologists and midwives in the less developed, rural and sparsely populated areas of Iran.⁷ Another study by Seyedfatemi and et al. (2015) showed that female-heads of households have a lower health status and less access to healthcare.⁸ These studies often focused on the health status and access of small groups of women of a specific area of the country. However, the laws guaranteeing rights of Iranian women to healthcare are rarely studied and compared to international laws. Limitations in access to healthcare can have its root in the inadequacy of national laws.

This paper aims to answer two questions: 1) what are women's rights to health in Iran according to national laws and policies? 2) In comparison to international human rights laws and the situation of women's right to health in Iran, do national laws adequately protect women's right to health? The answers to these questions will indicate which parts of national laws do not meet their intended purpose and need to be improved. Also, the results will be helpful in finding probable inconsistencies between the provisions of international human rights laws and domestic laws. In the

⁶ Ibid, paras 12 & 21

⁷ Karyani, AK. Azami, SR. Rezaei, S. Shaahmadi, F. Ghazanfari, S. 'Geographical distribution of gynaecologists and midwives in Kermanshah province (2008- 2013)' [2015] J Kermanshah Univ Med Sci. 19 (5) 294-302; Haghdust, AK. Kamiyabi, A. AshrafiAsgarabad, A. Sadeghirad, B. Shafiyani, H. Ghasemi, SH. 'The geographical distribution of the medical specialists and regional inequalities' [2011] Journal of Medical Council of Iran 28 (4) 411-419; Mostafavi, H. Aghlmand, S. Zandian, H. AlipouriSakh, M. Bayati, M. Mostafavi, S. 'Inequitable Distribution of Specialists and Hospital Beds In West Azerbaijan Province' [2015] Payavard Salamat 9 (1) 55-66; TaatiKeley, E. Meshkini, A. KhorasaniZavareh, D. 'Distribution of Specialists in Public Hospitals of Iran'[2012] Health Information Management 9 (4) 548-557.

⁸ Seyedfatemi, N. Rafii, F. Rezaei, M. Sajadi, M. 'Factors influencing the health promotion in Female-Headed Households: Golden Triangle of Money, Time and Energy' [2015] Journal of Health and Knowledge 10 (4) 13-22; Hajizadeh, M. Nghiem, HS. 'Hospital care in Iran: an examination of national health system performance' [2013] International Journal of Healthcare Management 6 (3) 201-210.

following sections, first, the laws and policies on women's health and the right to health in Iran are reviewed. Next, the situation of women's access to healthcare in Iran from four aspects (non-discrimination, physical accessibility, and affordability and information accessibility) is analysed. The conclusion section suggests necessary changes in the laws and policies of Iran to better realise women's right to health. The method of this study is content analysis of key international and national laws and documents on the equality of men and women, as well as women's health and right to health. At international level, main laws and the reports of the UN human rights committees and organizations and at national level, the constitution, development plans, health policies and laws, state's reports to the United Nations Treaty Bodies and academic literature are securitized. The data is collected from academic electronic databases and official webpages of Iran's government, such as Iran's Parliament Research Centre, and of the UN treaty bodies such as the United Nations Treaty Collections and the United Nations Official Document System.

7.3 WOMEN'S HEALTH AND THE RIGHT TO HEALTH IN IRAN

The Constitution of Iran guarantees non-discrimination in the enjoyment of the right to health. It obliges the government to support women during pregnancy, and child bearing and custody, as well as poor women without a guardian and old women.⁹ Women's health is defined as a complete physical, mental, spiritual and social welfare and not only the absence of diseases and disabilities by the law in Iran.¹⁰ Iran's laws on the health of women have a comprehensive approach that encompass health and underlying determinants of health such as nutritious food, social security, education and work, and involve different stakeholders and consider the health needs of women's life span.¹¹

The Charter of the Rights and Responsibilities of Women in Iran (2004) which is a non-binding statement about the rights and responsibilities of Iranian women recognises the right of women to health services, in particular, maternity care, safe delivery, prevention and treatment of sexually transmitted diseases and reproductive health.¹² According to this charter, the government needs to consider the health needs of women in all policies and programs, to remove all cultural, social and financial

9 Iran's Constitution 1979, art 21

10 Supreme Council of the Cultural Revolution. Policies and Strategies for Improving Women's Health 2007, art 1

11 The Council of Ministers of Iran. Directive on the Comprehensive Plan on the Development of Women and Family Affairs 2013.

12 Charter of the Rights and Responsibilities of Women in Iran 2004, part 3 Chapter 1

barriers to women's access to healthcare, and to increase women's knowledge and participation in making decisions related to their health. The government should take all the necessary means for preventing domestic violence against women and enhancing the knowledge of families about equal treatment of girls and boys according to this document.¹³ Also, the government is obliged to provide a system of advocacy and consultancy for the protection of women's rights and remedying the inequalities.¹⁴ The rights to healthy working conditions, and equal opportunities to work and development for men and women are other government obligations addressed by the law in Iran.¹⁵

In recent years, the health of women has improved significantly in Iran and now, it is ranked as one of the best in the Eastern Mediterranean Region. Women's life expectancy at birth increased from 51 in 1980 to 74.5 in 2014. Also, maternal mortality rate reduced by more than 80% from 1990 to 2008.¹⁶ Establishing countrywide Primacy Healthcare network and rural confinement facilities, prioritizing maternity care and training a large number of community midwives have had the main roles in improving maternal health in Iran.¹⁷ More than 95% of child deliveries are assisted by an educated healthcare assistant. However, there are significant disparities in the health status (particularly the average of life expectancy and number of maternal mortality) of women belonging to the different socio-economic groups of population living in different provinces of Iran. For example, life expectancy in the province of Sistan and Baluchestan is 12.6% less than in the capital city, Tehran. Also, the number of health facilities is not enough in remote rural areas of this province. Furthermore, more than 50% of maternal mortalities in deprived provinces are reported to be preventable.¹⁸

By the successful control of communicable diseases and improvement of maternity health around the country, now the main causes of Iranian women's diseases are related to their lifestyle.¹⁹ Chronic respiratory diseases, cancer and other NCDs are ranked as the major causes of death among Iranian women.²⁰ Iran recently has ad-

13 Supreme Council of the Cultural Revolution, *supra* note 10

14 The Council of Ministers of Iran. *Supra* note 11

15 Supreme Council of the Cultural Revolution, *supra* note 10

16 United Nations Development Programme. 'About Iran' (UNDP 2016) <<http://www.ir.undp.org/content/iran/en/home/countryinfo.html>> accessed 6 May 2016

17 Health Policy Council, Ministry of Health and Medical Education of Iran. *Achievements, Challenges and future views of Health system in Iran* (Tehran: Ministry of Health and Medical Education 2010) Introduction

18 UN Economic and Social Council. *Concluding observations on the second periodic report of Iran* (E/C.12/IRN/CO/2; 2013) para 23; Joulaei, H. Maharlouei, N. Razzaghi, A. Akbari, M. 'Narrative review of women's health in Iran: challenges and successes' [2016] *International Journal for Equity in Health* 15 (1) 1.

19 Ministry of Health and Medical Education of Iran, Office for Women's Affairs. *Macro Strategies on women's health in Iran* (2009) 7

20 World Health Organization. 'WHO statistical profile of Iran' (WHO 2015) <<http://www.who.int/gho/countries/im.pdf>> accessed 6 May 2016

vised a health program for the control of NCDs among adults that includes periodic check-ups and education on healthy lifestyle.²¹ But still the approach of the PHC has not changed to implement this program properly. Moreover, mental health has not got enough attention in the health policies of Iran. The prevalence of psychological disorders, particularly depression and anxiety is high among Iranian women.²² While, insurance companies do not cover mental health services appropriately; there is a shortage of related facilities and specialists around the country.²³

Another issue related to the health of women is child marriage that is permitted by the law in Iran. Girls are allowed to get married at the age of 13 and even younger (if the court agrees).²⁴ In 2013, about 32,000 girls younger than 15 years got officially married.²⁵ The number of unofficial child marriages is likely to be more. In addition, 2.8% of all births were to mothers younger than 18 years in 2012.²⁶ Early marriage and child-bearing can endanger the health of mothers and children. A more important issue about girls is that in general, the knowledge of Iranian children about sexual and reproductive health (SRH) is not enough. Insufficient SRH information and skills threatens the health of Iranian adults too. Iran does not have a national policy on SRH, but, it used to have a countrywide family planning program. Through this program, people could have access to some SRH services. Recently, in order to enlarge the size of population, policymakers decided to stop the provision of family planning services in the PHC system. Now these services are provided to people with high risk behaviour and high risk pregnancies.²⁷ Limited access to reproductive health information and contraceptives can result in unwanted pregnancies, sexually transmitted diseases, HIV infection, and pregnancy-related illnesses and death. Studies showed that the prevalence of HIV/AIDS among Iranian women has increased by 550 % from 2007 to 2015.²⁸ Most of these women are infected via having sex with their partners.²⁹ It seems that Iran is in an immediate need of a national SRH policy which empowers women and men in preserving their health.

21 Ministry of Health and Medical Education of Iran. Program of Iranian Women's Health (SABA) 2015, introduction

22 Ibid, Chapter on mental health

23 World Health Organization, Ministry of Health and Medical Education of Iran. *WHO-Aims Report on Mental Health System in the Islamic Republic of Iran* (MOHME, Tehran 2006) 5-7; Ministry of Health and Medical Education of Iran. Program of Mental Health Improvement 2011, p1

24 Iran's Civil Code 1991, art 1041

25 Iranian Students' News Agency. 'Marriage of girls' (Iranian Students' News Agency 2016) <<http://www.isna.ir/fa/news/93042514761/>> accessed 6 May 2016

26 Joghtaii, M. 'The girls who become mothers' (Islamic Republic News Agency (IRNA) 2016) <<http://www.irna.ir/fa/News/80936052/>> accessed 6 May 2016

27 Ministry of Health and Medical Education of Iran. Direction no. 1 on the Health of the Population 2013, art 1.

28 Joulaei, H. Maharlouei, N. Razzaghi, A. Akbari, M. Supra note 18

29 Fallahi, H. 'The latest statistics of women living with HIV in Iran' (Mashregh News 2016) <<http://www.mashreghnews.ir/fa/news/210498>> accessed 6 May 2016

Another major program of Iran about the health of women is reducing rates of caesarean section (C-section). Because of the high percentage of pregnant women who decide to have C-section without any medical reason, in the law for the Health Sector Reform 2014, the government offered incentives for natural confinement and put limitations on unnecessary C-sections. All health services related to natural confinement are free in public hospitals. In the case of unnecessary C-section, the medical specialist performing it and the hospital administrator will face punitive measures. Also, health insurance organizations will not reimburse the costs of such a procedure.³⁰

7.4 WOMEN'S RIGHT TO UNDERLYING DETERMINANTS OF HEALTH

The right to health is an inclusive right that includes not only a right to health facilities, services and products, but also a right to the underlying determinants of health such as food, shelter, healthy working conditions, a healthy environment and access to health related information.³¹ Almost all the development plans of Iran include programs to improve the determinants of health and empower women. Through providing equal educational opportunities for girls and boys, the rate of literacy among Iranian women has increased considerably in recent years. Statistics show that more than 80% of women were literate in 2013.³² But, still the rate of employment of women is much less than men.³³ They are often financially dependent to their spouses, fathers or children.

In the laws of Iran, men are regarded as the breadwinners of family, and women are considered to be in need of a male guardian to provide the necessities of life for them.³⁴ This notion of different roles of men and women has influenced employment and social security policies of the government. To support women and children who do not have a male guardian, Iran enacted the law on the Protection of Women and Children without a Guardian in 1992. This law guarantees the rights to financial support, vocational training and social security for these women and children.³⁵ Moreover, the government has issued an insurance and social security package for

30 Ministry of Health and Medical Education of Iran. Guidelines for implementing the Program of Health Sector Reform (2014) 52-74

31 General Comment no. 14 ICESCR, *supra* note 5, para43

32 President office. *100-day report of Deputy of Women's affair* (2013) Introduction

33 World Bank. 'Ratio of female to male labour force participation rate (%) (Modelled ILO estimate)' (World Bank 2017) <<https://data.worldbank.org/indicator/SL.TLF.CACT.FM.ZS>> accessed January 2017

34 Iran's Civil Code 1991, art 1105

35 Law on the Protection of Women and Children without a Guardian 1992 art 2 (3)

housewives but it is not accessible to women who do not have any source of income to pay the premium.³⁶

In general, Iran's programs for supporting women do not cover entire target population. In recent years, the number of women in need of financial support has increased. The economic crisis of the country caused by international economic sanctions, years of war and inappropriate resource management of the government have had a severe effect on the welfare of Iranians.³⁷ It has increased inflation and unemployment and decreased the financial accessibility of health services.³⁸ The effects have been more serious for Iranian poor women. In recent years, Iran is confronted with a new phenomenon of street women and a significant increase of poor addicted women and sex workers.³⁹ These women face more acts of violence and do not have equal access to the necessities of life such as health services, food and shelter. Protection from violence is an important part of women's right to health. In Iran, there is no official data about the prevalence of violence against women. In addition, the legislative means to combat domestic violence against women is not sufficient.⁴⁰ The right to health includes a right to be free from harmful traditions such as female genital mutilation (FGM). Different studies show that FGM is common among some ethnic communities in Iran.⁴¹ Based on the Islamic Punishment Law of Iran, mutilation is a criminal act.⁴² However, to eradicate such an act which is rooted in the culture of people, legislation is not enough.

7.5 WOMEN'S ACCESS TO HEALTHCARE IN IRAN

According to General Comment no. 14 ICESCR, to realize the right to health, states should ensure that health facilities, services and products are accessible to all. Accessibility has four dimensions; non-discrimination, and financial, physical and information accessibility. Health facilities, services and products should be provided

36 ASRIRAN. 'Details on Health Insurance Package for Housewives' (ASRIRAN 2016) <<http://www.asriran.com/fa/news/61225/>> accessed 5 June 2016

37 World Health Organisation (WHO), *Country Co-operation Strategy for WHO and Iran* (WHO, Tehran: WHO Country Office in Iran 2004)36; Moret, ES. 'Humanitarian impacts of economic sanctions on Iran and Syria' [2015] *European Security* 24 (1) 120-140.

38 UN General Assembly. *Situation of human rights in the Islamic Republic of Iran* (A/69/356 2014) 23-25

39 Karamouzian, M. Foroozanfar, Z. Ahmadi, A. Haghdoost, AA. Vogel, J. Zolala, F. 'How sex work becomes an option: Experiences of female sex workers in Kerman, Iran' [2016] *Culture, Health & Sexuality* 18 (1) 58-70.

40 UN General Assembly. *Supra* note 38, at 6

41 Mozafarian, R. *Tigh o sonnat* (Iran: NakojaAbad. 2011); RezazadeJalali, R. 'Cultural context of violence against women, with an emphasis on female genital mutilation in Port of Kang, Iran' (MSc thesis. Shiraz University, Iran 2009); Pashaie, T. Rahimi, A. Ardalan, A. Majlesi, F. 'Prevalence of female genital mutilation and factors associated with it among women consulting health centers in Ravansar City, Iran' [2012] *sjsph* 9 (4) 57-68.

42 Islamic Punishment Law of Iran 2009, art 269

to everyone without any kind of discrimination. They should be affordable to all; people without necessary means should be supported by appropriate health insurance. Also, health facilities, services and products should be physically accessible and within a safe physical reach of everyone, and the information related to them should be accessible to all.⁴³ In the following paragraphs, these aspects of the right to access healthcare in Iran are analysed.

7.5.1 Non-discrimination

The Constitution and health laws of Iran guarantee equity in access to healthcare for all. They do not exclude any individuals or groups from accessing health services, and often oblige the government to provide necessary financial means for disadvantaged groups of population particularly vulnerable women to access healthcare.⁴⁴ Women without an appropriate male guardian, widows, divorced women, women living with disabilities, immigrant and indigenous women, women belonging to ethnic and religious minorities, elderly women, street women, rural women, and poor women might have limited access to health services.

According to Iran's Constitution, abolition of all forms of unjust discrimination, and provision of equal opportunities for everyone to access food, housing, work, healthcare and social security are two important goals of the country.⁴⁵ However, in Iran's law, men and women are not equal in all of their rights. An example about the right to health is that the husband's consent is a prerequisite to married women's access to some health services such as permanent sterilisation, abortion, C-Section, infertility treatment, hysterectomy, sex reassignment surgery, organ transplant and cosmetic surgery.⁴⁶ Third party authorization requirements for accessing healthcare are against the right to health according to the Committee on Economic, Social and Cultural Rights (CESCR).⁴⁷

7.5.2 Financial Accessibility

Primary healthcare services such as immunization, maternity and child care, health education, and school, environmental and occupational health are free and funded by the government in Iran. The costs of secondary and tertiary health services are paid by patients, insurance companies and the government. In past years, the share of people of health services' costs has been considerably high. In 2014, Iran enacted

⁴³ General Comment no. 14 ICESCR, *supra* note 5, para12

⁴⁴ Iran's Constitution1979, art 21

⁴⁵ *Ibid*, art 20

⁴⁶ Mahmudian, S. Arzamani, M. Dolatabadi, T. *Consent and its Legal Aspects* (North Khorasan Medical University, Bojnord, Iran 2007) 29-30

⁴⁷ UN Committee on Economic, Social and Cultural Rights, *General comment no. 22 on the right to sexual and reproductive health* (2016) para 41

the Law for Health Sector Reform which aims to decrease patient's share of hospital services and to provide special financial support for the treatment of patients with certain chronic diseases.⁴⁸ However, still people on the lowest income cannot afford health services. They prefer to spend their little money on other necessities of life such as food; also, they prioritize the needs of their children's lives over themselves.

⁴⁹

Examples of vulnerable women who face more financial barriers to access health-care are female heads of households and old women. Female heads of households are prioritized in all national development plans and health insurance and welfare policies of Iran; however, these women, particularly if they are refugee, disabled or inhabitants of informal urban settlements or remote rural areas, are more likely to suffer from poverty.⁵⁰ Female heads of families have a lower socio-economic status, standard of living and health than others. The rate of malnutrition and mental diseases such as depression and drug addiction are higher in this group. Most of them are not employed and often cannot afford quality hospital care.⁵¹ Another vulnerable group is the old women who often are economically dependent to their spouses and children in the provision of instrumental support and care. Iran has several plans to support old poor people. However, the support is not adequate to overcome the socio-economic vulnerabilities of this group. Current economic crisis and increase of the costs of necessities of life have made the provision of instrumental support and care by children even more difficult.⁵² Recently, the number of old homeless people has been increasing.⁵³

7.5.3 Physical Accessibility

Iran is a very large country with a lot of cities and villages scattered in mountainous and desert areas. The Primary Healthcare system in Iran provides minimum necessary care throughout the country. Only a few rural areas do not have access to health facilities and trained attendance in child birth.⁵⁴ In Iran, the number of secondary and tertiary health facilities is satisfactory; but they are not distributed equally all

⁴⁸ The Law on Health Sector Reform in Iran 2014, at 1

⁴⁹ Seyedfatemi, N. Rafii, F. Rezaei, M. Hezaveh, MS. Supra note 8

⁵⁰ UN General Assembly. Supra note 38, at 18-21

⁵¹ Seyedfatemi, N. Rafii, F. Rezaei, M. Sajadi, M. Supra note 8; Hajizadeh, M. Nghiem, HS. Supra note 8

⁵² Kousheshi, M. Khosravi, A. Alizadeh, M. Torkashvand, M. Aghaei, N. *Population Ageing in I. R. Iran, Socio-economic, demographic and health Characteristics of The Elderly: Issues and Challenges* (Iran: United Nations Population Fund. 2014) 5-14

⁵³ ASRIRAN, 'The increase of the elderly population abandoned in the streets' (ASRIRAN 2016) <<http://www.asriran.com/fa/news/495909>> accessed 25 September 2017

⁵⁴ Kiadaliri, AA. Najafi, B., Haghparast-Bidgoli, H. 'Geographic distribution of need and access to health care in rural population: an ecological study in Iran' [2011] *Int J Equity Health* 10 (1) 39-48

over the country.⁵⁵ The government has offered several incentives to attract medical specialists to work in remote and rural areas, however, less developed provinces still lack specialists and hospital care.⁵⁶ As an example, frequently, the lack of access to gynaecologists and midwives in less developed, rural and sparsely populated areas is reported.⁵⁷ Some villages in remote or mountainous areas are cut off by snow for several months a year. Moreover, villagers might not have access to public transportation to visit a medical specialist in a city. Iran has trained a large number of community health workers and midwives, but they are not able to manage emergencies and complicated cases. Shortage of ambulances, medical equipment and female doctors endanger the health of pregnant women. This situation has resulted in more maternal mortality, and decreased women's quality of life in these areas.⁵⁸ In some of rural and remote areas, access to safe water and sanitation is limited too.⁵⁹

7.5.4 Information Accessibility

States are required to provide adequate resources of health information for everyone and to refrain from censoring, withholding or misrepresenting health information according to General Comment no. 14 ICESCR.⁶⁰ In Iran, health information is an important service provided by the PHC network. It has had a significant role in the improvement of the health of women and their families. However, at the level of medical specialist and hospital care, the opportunities to acquire health information and to participate in decision making are not satisfactory.⁶¹ For instance, a study showed that a significant number of pregnant women decided to have a C-section because of a lack of knowledge on delivery process, and unnecessary concerns about

55 Karimi, S. Moghadam, SA. 'Designing a health equity audit model for Iran in 2010' [2011] J ResMedSci 16 (4) 541-552.

56 Hajizadeh, M. Nghiem, HS. Supra note 8; Health Policy Council, Ministry of Health and Medical Education of Iran. Supra note 17; World Health Organisation, supra note 37 at 34

57 Karyani, AK. Azami, SR. Rezaei, S. Shaahmadi, F. Ghazanfari, S. supra note 7; Haghdust, AK. Kamiyabi, A. AshrafiAsgarabad, A. Sadeghirad, B. Shafiyani, H. Ghasemi, SH. supra note 7; Mostafavi, H. Aghlmand, S. Zandian, H. AlipouriSakh, M. Bayati, M. Mostafavi, S. supra note 7; TaatiKeley, E. Meshkini, A. KhorasaniZavareh, D. supra note 7

58 Nurizade, R. Daneshkohan, A. Bakhtariaghdam, F. 'The rights of women in pregnancy and child birth' [2012] Medical Law 6 (21) 171-186.

59 WHO Regional Office for the Eastern Mediterranean, *Country Co-operation Strategy for WHO and Islamic Republic of Iran 2010-2014* (WHO Regional Office for the Eastern Mediterranean 2010) 30

60 General Comment no. 14 ICESCR, supra note 5, para 12

61 Hasandust, F. M. Tabatabaai, Ch. M. Hasandust F.Z. Younesi, MA. H. 'Evaluation of mothers' knowledge of the Charter of the rights of pregnant women' [2012] Proceedings of the First National Conference on Applied Research in Public Health and Sustainable Development in Iran at 771

the health of the child. In some cases, medical specialists even recommend them to have a C-section without any medical reason.⁶²

7.6 DISCUSSION AND CONCLUSION

The review of health laws and policies of Iran indicates that almost all the obligations defined in international human rights treaties for the protection of women's right to health are covered by national laws. Iran's Constitution recognizes the right to health as a fundamental human right of everyone. To realise the right to health, there should not be anyone deprived from this right. All the vulnerable groups of women who cannot afford healthcare and are not covered by current support programs should be identified and supported. Disparities in the health status of women belonging to different socio-economic groups of population and their access to healthcare should be removed. Iran should take steps immediately to improve the health and living situation of the inhabitants of remote and rural areas by providing enough healthcare facilities and urban infrastructure such as appropriate sanitation and safe water. Particularly, Iran should increase access to midwives and gynaecologists in these areas.

Empowering women by providing more opportunities for them to work will help them to become independent and have more control over their lives and health. Besides, enhancing the knowledge of society and women themselves about women's rights will be helpful in removing discrimination and violence against women. Nevertheless, effective deterrent judicial means for the protection of women against violence are necessary.⁶³ The law that requires the consent of the husband to access health services is in contrast with the wife's rights to autonomy and control of her body and health, and should be amended. Also, at the level of health services, more attention should be paid to the mental, and sexual and reproductive health of women and prevention of NCDs.

The health of girls is very important for individual and public health. Child marriage should be prohibited in Iran and children should receive age-appropriate education about sexual and reproductive health. An increase in the number of divorced girls in Iran necessitates especial attention of the government to empowering these children and providing them with social security measures and support. Since child marriage often happens among low socio-economic groups of society, the government's ignorance of the economic and social rights of these children will endanger

62 Sharifinic, N. Karimi, N. Abbasi, Z. Reasons for choosing C-section from the viewpoint of Iranian women[2012] Proceedings of the first National Conference on Applied Research in Public Health and Sustainable Development in Iran at 916

63 *General comment no. 22 on the right to sexual and reproductive health* supra note 47 para 41

their future lives. The right to health is a right to underlying determinants of health too. Therefore, homeless women should be provided with a shelter; malnourished women should receive nutritious food, and poor women should be given social security means. Everyone, according to Iran's Constitution and international human rights laws should be provided with an adequate standard of living.

Finally, defining rights in the Constitution or legislation is not enough for the protection of rights; they should be translated into practice . Iran should use all necessary means including legislative, administrative, budgetary, and judicial measures towards the full realization of women's right to health. National plans on women's empowerment and support should be interpreted in provincial programs and action plans. They should include detailed lists of related authorities and their responsibilities. Moreover, a monitoring system and certain national benchmarks for tracing the progress of these plans should be established in Iran. Appropriate deterrent laws and sanctions should be considered for every third party, including men who violate the rights of women to access healthcare. Society has the potential to help the government to identify women suffering violation of their rights. The government should facilitate this collaboration and prepare needed facilities.



Chapter 8

The Role of Male Guardians in Women's Access to Health Services in Iran

This part of the study was published by the International Journal of Law, Policy and the Family
2018; 32(2):230-249.

8.1 ABSTRACT

Based on the law in Iran, men are regarded as the heads of families, guardians of women, and responsible for funding women's necessities of life. Having a male guardian might be an advantage for poor women, provided the male guardian fulfils his obligations. To support women without a male guardian, several provisions are defined in the laws of Iran. However, some eligible women still face difficulties in enjoying their rights such as the rights to social security and healthcare. A woman, who has a husband with enough financial resources, but he does not provide access to the necessities of life such as healthcare for her, is not eligible to receive governmental financial aid. In such cases, the law recognizes the right of the wife to sue him and start a court proceeding for divorce; however, this is not an appropriate solution for a woman with a low socio-economic status. In addition, the role of guardianship gives men the right to interfere in some rights of women, including the right to access health services. This policy constitutes a discriminatory treatment of women and a violation of their right to control their body and health. Women are fully capable adults, and able to make autonomous decisions about their lives. The government of Iran should reconsider the laws and policies which negatively impact the ability of women to enjoy their right to health. Also, the government should identify and remove all barriers in the law and cultural attitudes of the population that hinder women's access to health services and social security. Women's rights should be guaranteed regardless of their marital status.

Keywords: Right to health; Women's rights; Access to healthcare; Marital rights; Islamic human rights; Iran

Chapter 9

Equity in Access to Healthcare for Children; the Domestic
Implementation of International Human Rights Law in
Iran

This part of the study was published in the Journal of Medicine and Law 2017; 36(2):59-80.

9.1 ABSTRACT

Achieving equity in access to healthcare requires the provision of socially, physically, and economically accessible health services for entire population. The aim of this study is to characterize laws and policies regarding the right to access healthcare for children in Iran and to identify the extent to which they are congruent with human rights standards of non-discrimination. In Iran, the constitution and national laws guarantee equity of everyone in the enjoyment of the right to health but access for some groups of children, such as the poor and illegal immigrants, to health services is not equitable. To solve the problem, barriers to equal access to health services in laws and practice should be eliminated and immediate measures should be adopted for identifying disadvantaged children and improving their access to healthcare.

Keywords: Children; Right to health; Children's rights; Access to healthcare; Equity; Islamic Republic of Iran



9.2 INTRODUCTION

The health of children has an important role in realizing their right to survive, grow and development. Due to physical and mental immaturity, discrimination endangers the health and development of children and makes them more vulnerable to exploitation, abuse and violence. Approximately 22 million children (population under the age of 18) live in Iran which constitutes almost 28% of the total population.¹ In recent decades, by the establishment of the Primary Healthcare (PHC) system across the country, children's survival and health have improved significantly and the main causes of children's diseases and disabilities have been eliminated or controlled in Iran.² Disparities can however be seen in the health status of children and their access to health services around the country.³

The constitution, national laws and public policies indicate whether a state has made efforts to improve the realization of children's rights.⁴ Iran has made a commitment to tackle inequalities in access to healthcare in its constitution and development plans. The purpose of this paper is to characterize laws and policies regarding the right to access healthcare for children in Iran and to identify the extent to which they are consistent with human rights standards of equity and non-discrimination. The results of these kinds of studies will increase awareness of the situation and help to identify the causes of violations and generate political commitment to take action.⁵ The study uses the legal framework of accessibility determined by General Comment no. 14 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) to analyse access to healthcare for children. According to this document, health services have to be geographically and economically accessible to all, without discrimination of any kind. Information regarding these services needs to be available to the entire population.⁶

To undertake this research, the original national legislative texts (Persian documents were translated by the researcher), international human rights laws and treaties

1 United Nations Children's Fund (UNICEF), *The State of the World's Children Report 2015 Statistical Tables* (UNICEF 2015) 38.

2 Health Policy Council, Ministry of Health and Medical Education of Iran (MOHME), *Achievements, Challenges and future views of Health system in the Islamic Republic of Iran* (vol 2, Ministry of Health and Medical Education 2010) 266.

3 WHO Regional Office for the Eastern Mediterranean, *Country Co-operation Strategy for WHO and Islamic Republic of Iran 2010–2014* (WHO Regional Office for the Eastern Mediterranean 2010) 7.

4 Heymann J. McNeill, K. Raub, A. 'Assessing Compliance with the CRC Indicators of Law and Policy in 191 Countries' [2014] *International Journal of Children's Rights* 22 (3) 425.

5 United Nations Children's Fund (UNICEF) Innocenti Research Centre, *The general measures of the convention on the rights of the child the process in Europe and central Asia* (UNICEF 2006) 34.

6 UN Committee on Economic, Social and Cultural Rights. *General Comment no. 14 ICESCR: The Right to the Highest Attainable Standard of Health* (2000) para 12.

and research articles were used. Legal texts were acquired through the United Nations treaties' and the organizations' web pages, Iran's Parliament and organizations' websites and the hard copy of laws at the Ministry of Health and Medical Education of Iran (MOHME). Where it was necessary, supplementary data was gathered from reliable secondary sources, such as reports and concluding observations of international human rights treaties and organizations, as well as the reports of Iran.

Iran is a member of the United Nations, the World Health Organization (WHO) and the International Labour Organization and also a party to several treaties on human rights, such as the ICESCR, the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Rights of the Child (CRC). CRC is the main convention on the rights of children worldwide. Upon ratification of the CRC, Iran made a general reservation to not apply any articles which might conflict with the Islamic laws and the international legislation which is in effect in Iran.⁷

In this article the current situation of children is explained to identify whether the current means for the protection of children are sufficient. The analysis of laws should not only be about the extent to which the legislation is effective to the CRC, but also it should include the effects of legislation on the daily life of children.⁸ In this study, the right to health and the obligations of states about children's right to health are explained. Then, the obligations of states defined in the international treaties that are applicable to Iran are reviewed. Then the concepts of equity and non-discrimination are explained. Subsequently, after giving a summary of the health system of Iran, an analysis of national and international laws on different dimensions of accessibility of health services for children is provided. In conclusion, areas of improvement in Iran's laws and policies on equity and non-discrimination for children in the enjoyment of the right to health are presented.

9.3 RIGHT TO HEALTH

The Universal Declaration of Human Rights (UDHR) indicates that everyone is born with inherent dignity and equal in rights and entitled to the protection of his/her fundamental rights without discrimination of any kind.⁹ The right to health that is recognized in various international human rights laws and treaties is one of those fundamental rights. According to the UDHR, 'everyone has the right to an adequate

7 United Nations. 'Treaty Collection, Declarations and reservations' (UN 2015) <https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtdsg_no=iv-11&chapter=4&lang=en> accessed 18 November 2015.

8 Lundy, C. *Legislation Review and Reform on Behalf of Children's Rights' in Assessing Compliance of National Legislation with International Human Rights Norms and Standards* (UNICEF 2008) 25.

9 Universal Declaration of Human Rights 1948, art 1-2.

standard of living, adequate for the health and well-being of him/herself and of his/her family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control'.¹⁰

The right to health is guaranteed in article 12 of the ICESCR as 'the right to the enjoyment of the highest attainable standard of physical and mental health'.¹¹ The ICESCR interpreted this right in its General Comment no.14, as the right to the enjoyment of all facilities, services and products necessary for the realization of this right. It ranges from timely and equal access to basic preventive, curative, rehabilitative health services, and socio-economic determinants of health such as food, water, housing, adequate sanitation, a healthy environment and safe and healthy working conditions. It also includes access to health-related education and information and individuals' participation in health-related decision-making.¹²

According to the ICESCR, states are required to progressively realize economic, social and cultural rights by taking steps to pursue the goals of the convention and by using the maximum of available resources. They are expected to realize the minimum core obligations immediately after ratifying the covenant.¹³ Non-discrimination, in the realization of human rights, is a fundamental core obligation in all human rights treaties. General Comment no. 14 ICESCR indicates that to realize people's right to health, states should provide available, accessible and acceptable healthcare facilities, services and products of good quality for all. These requirements are referred to as the Availability, Accessibility, Acceptability, and Quality (AAAQ) framework. To be accessible, an adequate number of health facilities, services and products should be provided, physically as well as economically accessible to everyone without discrimination of any kind. The notion of accessibility also includes the accessibility of information.¹⁴

¹⁰ Ibid art 25 (1).

¹¹ International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966, art 12 (1).

¹² General Comment no. 14 ICESCR, supra note 6 para4

¹³ UN Committee on Economic, Social and Cultural Rights. *General Comment no. 3 ICESCR: The Nature of States Parties' Obligations* (1990) paras 1, 2, 9 & 10; ICESCR, supra note 11, art.2.

¹⁴ General Comment no. 14 ICESCR, supra note 6 para 12.

9.4 OBLIGATIONS OF STATES ON CHILDREN'S RIGHT TO HEALTH

According to the CRC, every child has an inherent right to life, a maximum extent possible of survival and a standard of living adequate for his/her comprehensive development.¹⁵ Based on the Convention on the Rights of the Child in Islam (CRCI), a child, from the time that (s)he is a foetus, has a right to life and care.¹⁶ The problem in the realization of children's rights is that traditionally, in most societies, children are not regarded as rights holders.¹⁷ The Geneva Declaration on the Rights of the Child (1924), as the oldest document about the rights of children, declares that all the material and spiritual means necessary for the normal development of a child must be provided to him/her. It adds 'the child that is hungry must be fed; the child that is sick must be nursed; the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succoured'.¹⁸ This comprehensive notion of children's rights has been entered into CRC. Based on General Comment no. 15 CRC on the right of the child to health, 'children's right to health is an inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential, and live in the conditions that enable the child to attain the highest standard of health through a holistic approach to the underlying determinants of health'.¹⁹ Particularly, the CRC requires the states to reduce infant and child mortality and provide essential healthcare and nutritious food to all children. Mothers should have access to appropriate pre-natal and post-natal healthcare. Society, parents and children should have access to necessary child health education and be supported in its use. Traditional practices which are harmful to the health of children should be abolished.²⁰

Similar to other human rights, the right to health imposes three kinds of obligations on States: to respect, protect and fulfil. States should refrain from denying or limiting equal access of everyone to health services and take measures to prevent third parties from acting in this way. States are required to adopt all the necessary measures (legislative, administrative, budgetary, judicial and promotional) towards the full

15 UN General Assembly. Convention on the Rights of the Child (CRC) 1989, art 27.

16 Cairo Declaration on Human Rights in Islam 1990, art 6.

17 UN Committee on the Rights of the Child. *General comment no.5 CRC: General measures of implementation of the Convention on the Rights of the Child* (2003) para 66.

18 Geneva Declaration of the Rights of the Child 1924, para3.

19 UN Committee on the Rights of the Child, *General comment no. 15 CRC: the right of the child to the enjoyment of the highest attainable standard of health* (2013) para2.

20 CRC, supra note 15, art 24.

realization of economic, social and cultural rights including the right to health.²¹ To realize the rights of children, states should ensure their legislation is compatible with the principles and provisions of the CRC and adopt relevant national law. In the case of national legislation conflicting with the CRC, priority should be given to the CRC. National laws should be reviewed systematically, the implementation should be monitored and if necessary new or revised laws should be enacted. Impact assessment of existing legislation and policies is essential to ensure that laws are protecting children's rights effectively. Impact assessment should be conducted toward other policies which are not directly concerned with children, such as social security, taxes and immigration but might affect children.²²

9.5 RIGHT TO HEALTH IN IRAN

Health and the right to health are considered in the Constitution of Iran. It protects citizens' human rights including the right to health and social security, in conformity with Islamic criteria. In the Constitution, improvement of the living situation of the population and alleviation of poverty through expansion of the health services network and insurance coverage are emphasized.²³

The health system of Iran is structured as a nation-wide network providing three levels of health services; primary, secondary and tertiary. The primary healthcare services are provided and financed by the government, while the others are run by the public and private sectors. Healthcare facilities are distributed throughout the country, based on three main criteria; density of the population, and its distribution and geographical accessibility.²⁴ Immunization, prevention and control of communicable diseases, maternal and child healthcare and family planning are some services provided by the primary healthcare system.²⁵ At the secondary and tertiary levels, more complex healthcare services are provided.

21 General Comment no. 14 ICESCR, *supra* note 6 paras 33-36.

22 UNICEF, *FACT SHEET: Implementation guidelines for the Convention on the Rights of the Child* (UNICEF, 2007)1-2.

23 Iran's Constitution 1979, art 20 & 29.

24 Rahbar, M. *Primary health care in Islamic Republic of Iran* (Ministry of Health and Medical Education 2009)18-22.

25 WHO Regional Office for the Eastern Mediterranean, *supra* note 3 at 23.

9.6 CHILDREN'S RIGHT TO HEALTH IN IRAN

According to the report of the United Nations Children Fund (UNICEF), by having a strong health and education network and infrastructure, Iran is on track to achieve most of the Millennium Development Goals including decreasing poverty and hunger, providing primary education, and improving child and maternal health.²⁶ There are several laws and legislation about children's health and welfare in Iran. Various interpretations of the term "child" are given by different national laws in Iran. In the health and welfare systems of Iran, this term is defined as everyone younger than 18 years. In this country, several health programs for children of different ages exist that comprise three parts: young children, school children and adolescents.

9.6.1 Young Children

In recent years, Iran has made considerable efforts to improve health in early childhood which resulted in a significant increase of children's survival rate. The under-five mortality rate decreased from 73 per 1,000 live births in 1990 to 17 in 2013, which indicates that children are more protected from diseases and better nourished than before.²⁷ Training local midwives, establishing confinement facilities in rural areas, setting up Child-Friendly Hospitals, MANA project (Integrated care for the diseases of children), and Well Child Care (WCC) are some of the programs for the protection and improvement of children's health in Iran.²⁸

Supporting women during pregnancy and taking care of their children are guaranteed by Article 21 of Iran's constitution and the law on Welfare System of Iran (2004).²⁹ Prenatal and postnatal care are primary services of the PHC network in Iran.³⁰ Maternity leave (at least for 6 months), reduced working hours per day for two years and breastfeeding facilities at the mother's workplace are defined as the rights of mothers provision of in the national laws of Iran. The law indicates that during maternity leave, the mothers' work position should be preserved.³¹ However, the rate of breastfeeding is not satisfactory; it contributes to low nutrition levels and underweight children.³² Another issue about this group of children is the prohibition

26 United Nations Children's Fund, *Revised country programme document, Islamic Republic of Iran (2012-2016)* (E/ICEF/2011/P/L.39, 2011) 3.

27 UNICEF, *Annual Report for Iran 2012 (MENA)* (UNICEF 2012) 1; UNICEF, *supra* note 1 at 38.

28 Health Policy Council of Ministry of Health and Medical Education of Iran. *Supra* note 2 at 273-283.

29 Iran's Constitution, *supra* note 23, art 21; Comprehensive Welfare System law 2004, art1.

30 Hamidian, Kh. *The right to health in Iran* (Country report, University of Aberdeen, 2013) 10.

31 Directive on the Promotion of Breastfeeding and Support of Breastfeeding Mothers (PBSBM) 1996, art 3-6; The Directive on (PBSBM) 2005, art 3; Amendments of the Directive on (PBSBM) 2005, art 1; Amendments to the Directive on (PBSBM) 2007, art 1.

32 UNICEF. *UNICEF in Iran 2012-2016* (UNICEF 2012)2.

of abortion. In accordance with the laws of Iran, the foetus has a right to life, and abortion is only allowed before the 4th month of pregnancy, if the health situation of the mother, or child, makes it unavoidable.³³

9.6.2 School Children

Based on Iran's Law of Schools (2000), access to clean water and a healthy environment, appropriate sanitation and safe food should be provided at schools. Every student gets a general medical screening at the time of enrolment in school and, thereafter at least once per year. Schools must take the necessary measures to control communicable diseases among students. Special attention should be paid to the education of disabled students by providing additional facilities at school.³⁴ According to the number of students, schools should have a health expert available, or use a local health expert for providing primary healthcare to students and taking care of the school's environmental health.³⁵ In practice, the current system does not properly respond to the health problems of children, due to the large number of students, inadequate insurance benefits and insufficient number of health experts at schools. There is a gap in providing these services for children who drop out of school too.³⁶

9.6.3 Adolescents

In Iran, unhealthy behaviour, such as poor eating choices, smoking, substance abuse, lack of exercise and risky sexual behaviour are increasing among adolescents. The rates of suicide, mental illnesses, injury, disability and death due to accidents are growing among children in this age group.³⁷ The UNICEF states that to combat these problems, adolescents should get appropriate information about the healthy lifestyle, including safe and respectful social and sexual behaviour and the ways to cope with stress in life.³⁸ The Comprehensive Program of Adolescents' and Youngsters' Health (2010), now in the pilot stage in Iran, consists of several education programs on the healthy lifestyle and nutrition, exercise, proper social behaviour, smoking, drug addiction and unsafe sexual relationships.³⁹ In the 5th Economic, Social and Cultural Development Plan of Iran (2011), the government is obliged to provide educational

33 Law on Medical Abortion 2005, art 1.

34 Iran's Law on Health of Schools 2000 art 4; Health Policy Council Ministry of Health and Medical Education of Iran, *supra* note 2 at 285-289.

35 Directive on Providing, Maintaining and Promoting the Physical, Mental, Social Health of Students 2005, art 1

36 Health Policy Council MOHME, *supra* note 2 at 296.

37 UNICEF *supra* note 32 at 2-3; Nasehi, A. 'Children and Adolescents' Mental Health Policy Document has been Published' (IRNA 2011) Health 1.

38 UNICEF *supra* note 32 at 26.

39 Health Policy Council MOHME, *supra* note 2 at 287-9.

programs to improve the physical and mental health of children.⁴⁰ The Program of Mental Health Improvement (2011-2015) aimed to improve the mental health of different groups including children. One tenth of primary and secondary schools has a part time or full time counsellor available. There is no official data on the prevalence of mental disorders among children in Iran. In general mental health education, facilities and professionals are insufficient in this country.⁴¹

Adolescents' right to health includes education on family planning, contraceptives and sexually transmitted diseases. The information should be provided to them regardless of their marital status or the consent of their parents.⁴² In Iran, there is no education at schools about these issues. Adolescents themselves have to search for reproductive and sexual health services. They are often not willing to use these services because of stigma, the fear of being judged or shame. Related prevention services are not appropriate, attractive and accessible enough for adolescents.⁴³ In recent years, Iran has focused more on young children's health and survival. Now the time has come to pay more attention to the health needs of children in other age groups, especially adolescents. Iran's PHC programs have started to change in order to tackle other health problems which are more common among young people and adolescents such as traffic accidents, obesity, HIV/AIDS, mental diseases, addiction and to meet the needs of deprived areas.⁴⁴

9.7 EQUITY IN ACCESS TO HEALTHCARE AMONG CHILDREN IN IRAN

Discrimination is defined by the CESCR as 'any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing of Covenant rights'.⁴⁵ Several human rights treaties such as the ICCPR and the

⁴⁰ The Fifth Economic, Social, Cultural Development Plan of Iran (2011-2016) art 19.

⁴¹ Ministry of Health and Medical Education of Iran. Program of Mental Health Improvement 2011, p1; World Health Organization, *WHO-aims report on mental health system in the Islamic Republic of Iran* (WHO and Ministry of Health and Medical Education of Iran, 2006) 5-7.

⁴² UN Committee on the Rights of the Child, *General comment no. 4 CRC: Adolescent Health and Development in the Context of the Convention on the Rights of the Child* (2003) para29.

⁴³ UNICEF Iran Country Office and Ministry of Health and Medical Education of Iran, *Looking Ahead: HIV Prevention amongst Young People in the Islamic Republic of Iran* (Ministry of Health and Medical Education of Iran 2014) 2.

⁴⁴ WHO Regional Office for the Eastern Mediterranean, *supra* note 3 at 30-31.

⁴⁵ UN Committee on Economic, Social and Cultural Rights. *General Comment no. 20 ICESCR: Non-discrimination in economic, social and cultural rights* (2009) para7.

CRC prohibit any discrimination against children. All mechanisms and programs in a country should be strengthened for the protection of every child, particularly those who are vulnerable, such as girls, the disabled, orphans, abandoned and street children, children living in poverty, children of immigrants, indigenous or minority groups.⁴⁶

To realize children's rights, states should ensure that all domestic laws are fully compatible with the principles and provisions of the CRC and can be applied and enforced appropriately.⁴⁷ In this part of the study, the laws related to the access of children to health facilities, services and products in Iran are analysed. According to General Comment no. 14 ICESCR, accessibility has four dimensions; non-discrimination, physical accessibility, affordability and information accessibility.⁴⁸

9.7.1 Non-discrimination

Everyone has a right to a health protection system that provides equal opportunity to all to enjoy the right to health. Health facilities, services and products should be provided in a sufficient quantity and accessible to all, without any type of discrimination. Special attention should be paid to marginalized and vulnerable sections of society. According to the CRC, every child within a country's jurisdiction is entitled to measures of protection, 'irrespective of the child's, or his/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'. A child who is a refugee or seeking refugee status, or a child affected by inter-country adoption also has the same rights.⁴⁹

Based on Iran's Constitution, the abolition of all forms of unjust discrimination and the provisions of equitable opportunities for all are defined as fundamental goals of the country. It indicates that all the people of Iran, regardless of their tribe or ethnic group, have equal rights; colour, race, language and other status will not grant any privileges.⁵⁰ In this part of the study, both direct and indirect discrimination are considered. The universal list of vulnerable children, who may face discrimination, is long but more common grounds of discrimination include gender, birth registration, nationality, ethnic origin, disability, and poverty.

46 Vienna Declaration and Programme of Action 1993, paras 12-24.

47 General comment no. 5 CRC, *supra* note 17, para1.

48 General comment no. 14 ICESCR, *supra* note 6, para12.

49 Convention on the Rights of the Child, *supra* note 15, art 2 & 22.

50 Iran's Constitution 1979, *supra* note 23 art 19.

- *Girls*

Around the world, girls may face neglect, infanticide, inadequate feeding in infancy, genital mutilation and selective abortion. It is probable that they are expected to undertake excessive family responsibilities and are deprived of education. Discrimination against girls affects their survival and future lives and restricts their capability to contribute to society.⁵¹ The non-discrimination requires that both girls and boys have equal access to health services, adequate nutrition, and a safe environment.⁵²

In the laws of Iran, no difference is made between boys and girls in access to health services. Recent survival rates of boys and girls do not show a significant difference.⁵³ The Charter on the Rights and Responsibilities of Women in Iran (2004) protects girls' right to the necessities of preserving their mental and physical health, including safe and adequate food, housing and health services, as is applicable for boys. Girls who are victims of abuse or violence have the right to rehabilitation services, and girls without guardians have the right to social security and free health insurance.⁵⁴ To support girls who are at the risk of social harm, and lack necessary family and social support, special shelters have been established in the country. The purpose of these shelters is to help these girls meet their minimum economic needs and protect them from more social harms.⁵⁵

Another part of children's rights, especially important for girls' health, is the right to be free from harmful traditional practices affecting their health, including early marriage and genital mutilation. Based on the Iranian law on Supporting Children and Young Adults (2002), infliction of any kind of physical and mental harm and injury to children is forbidden and punishable.⁵⁶ Based on the Islamic Punishment Law of Iran, mutilation in general is regarded as a crime.⁵⁷ In a few ethnic groups, genital mutilation is common, even though its prevalence has decreased in recent years in Iran.⁵⁸ The government should take necessary measures to stop female genital mutilation. Another issue endangering the health of girls in Iran is that they are allowed to get married at the age of 13 and earlier if the court agrees.⁵⁹ In 2013,

51 UN Committee on the Rights of the Child. *General Comment no. 7 CRC: Implementing child rights in early childhood (2006)* para 11b.

52 General comment no. 14 ICESCR, *supra* note 6 para 22.

53 UNICEF. *Supra* note 1 at 38.

54 Charter of Rights and Responsibilities of Women in Iran 2004, art 15-58.

55 Islamic Republic of Iran, *Report of Islamic Republic of Iran on Implementation of the International Covenant on Economic, Social and Cultural Rights* (E/C.12/IRN/2, UN Economic and Social Council 2011) 159.

56 Law on Supporting Children and Young Adults 2002, art 2.

57 Islamic Punishment Law of Iran 2009, art 269

58 Mozafarian, R. *Tigh o sonnat* (Nakojā Abad, Iran 2011); Rezazade Jalali, R. 'Cultural context of violence against women, with an emphasis on female genital mutilation in Port of Kang, Iran' (MSc thesis. Shiraz University, Iran 2009); Pashaie, T. Rahimi, A. Ardalan, A. Majlesi, F. 'Prevalence of female genital mutilation and factors associated with it among women consulting health centers in Ravansar City, Iran' [2012] *sjsph* 9 (4) 57-68.

59 Civil Code of Iran, art 1041

about 32.000 children younger than 15 years were officially married,⁶⁰ and 2.8% of all births were to mothers younger than 18 years in 2012.⁶¹

- *Children Without an Identity or Birth Certificate*

During 2005-2012, the rate of birth registration was 98.6% in Iran.⁶² Not having a birth certificate can be a barrier for realizing some fundamental human rights, such as the right to identity, access to immunization, healthcare, education and protection from underage marriage. Children born out of wedlock may suffer the consequences of discrimination against their parents.⁶³ Based on Iran's law, a child who is borne out of a non-registered marriage, or out of wedlock, cannot be granted a birth certificate unless both parents are present for the registration.⁶⁴ In the culture of Iranian society, having a child out of wedlock is regarded as abhorrent. In these cases, parents are not willing to take on the official parenting responsibility and might try to get rid of the child⁶⁵; this threatens the life of the child.

Reports show that there are thousands of children without identity documents in Iran, particularly from illegal immigrants, who were born in unregistered marriages. Even a child who is born in a marriage between an illegal immigrant and an Iranian woman is not guaranteed an Iranian identity. It is customary in Iran that the father's nationality determines the nationality of the child, therefore if the foreigner father does not apply for the child's identity papers from his country, the child will not have an identity and will be regarded as stateless in Iran.⁶⁶ When the child reaches the age of 18, under certain conditions, he/she can apply for the Iranian nationality. Article 27 of the International Convention Relating to the Status of Stateless Persons (1954) requires states to issue identity papers to every stateless person within their territory who does not possess a valid travelling document.⁶⁷ These children should be guaranteed an identity certificate and have the opportunity to enjoy their rights to health, education and social security.

60 ISNA. 'Marriage of girls' (ISNA, 16 July 2014) <<http://www.isna.ir/fa/news/93042514761/>> accessed 03 June 2016

61 Joghtaii, M. 'The Girls who become Mothers' (IRNA, Social(women and adolescents) 4 December 2013) <<http://www.irna.ir/fa/News/80936052/>> accessed 3 June 2016

62 UNICEF, *supra* note 1 at 86.

63 General comment no. 7 CRC, *supra* note 51, para 12.

64 UNICEF. 'Babies in Iran registered for key services, thanks to mobile unit' (UNICEF 2015) <http://www.unicef.org/iran/reallives_2608.html> accessed 15 June 2015.

65 Sarpoosh, 'Abandoned children' (Sarpoosh 2018) <<http://www.sarpoosh.com/society/social-damages/social-damages970307264.html>> accessed 15 August 2018

66 Mohammadi, P. '100.000 children without ID card in Iran' (Jame Jam 2012; social) 1.

67 UN Convention Relating to the Status of Stateless Persons 1954, art 27.

- Refugees, Asylum Seekers, Illegal and Legal Immigrant Children

Children displaced from their homes usually face poverty, starvation and the lack of essential basic services; displacement exposes them to violence, sexual attacks and torture.⁶⁸ Based on human rights treaties, asylum seekers, immigrants and refugees, including their children, irrespective of their nationality, immigration status or statelessness and legal status should have the same rights as nationals of a country.⁶⁹ Foreigners, lawfully residing in a state, have the right to health protection, medical care and social security in accordance with the laws of the nation.⁷⁰

Iran is one of the largest host countries for refugees in the world.⁷¹ The 5th Economic, Social and Cultural Development Plan of Iran (2010-2014) required foreigners, residing in Iran, to have health insurance.⁷² The Welfare Law 2005 indicates that non-citizens living in Iran can benefit from social security support with regard to Sharia law, concords and mutual actions with their country of origin.⁷³ There is no law that limits access of any individual or group to health services in this country. Refugees who live in refugee settlements have access to free health services in Iran. There is a large number of undocumented immigrants in the country. Their legal status has a direct bearing on the enjoyment of their children of the basic rights, such as access to health services.⁷⁴ The problem is that usually illegal immigrants living in Iran are poor and have difficulties accessing the necessities of life and healthcare. It is not unusual to see the children of illegal immigrants working in the streets of mega cities; thereby making them vulnerable to the violation of their rights. Another issue regarding legal and illegal immigrants, who have entered Iran over the last three decades from neighbouring countries, is their resistance to change native customs, such as the forced marriages of young girls or preventing them from attending school.⁷⁵

- Indigenous and Ethnic Minority Children

Around the world, indigenous children often suffer poorer health compared to other children. The Committee on the Rights of the Child urges states to ensure that these

68 Oberg, CN. 'Embracing international children's rights: from principles to practice' [2012] *ClinPediatr (Phila)* 51 (7) 619-624.

69 UN Committee on the Rights of the Child. *General comment no. 6 CRC: Treatment of Unaccompanied and Separated Children Outside their Country of Origin* (2005) para 4.

70 UN Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live 1985, art 8 (3).

71 WHO Regional Office for the Eastern Mediterranean, *supra* note 3 at 16.

72 The Fifth Economic, Social, Cultural Development Plan of Iran, *supra* note 40, art 95.

73 The Law on the Structure of the Comprehensive Welfare and Social Security 2005, art 1 (3).

74 UNICEF, *supra* note 22 at 1-2.

75 Islamic Republic of Iran, *The Third Periodic Report on the Convention on the Rights of the Child: The Islamic Republic of Iran* (United Nations Committee on the Rights of the Child, 2013) 7.

children have access to culturally appropriate services related to health, nutrition, education, social services, housing and sanitation. States are required to take measures to ensure indigenous children are not discriminated against in their right to health. They also have a positive duty to combat malnutrition and infant, child and maternal mortality.⁷⁶ States are required to work together with the indigenous communities to eradicate harmful practices, such as early marriage and female genital mutilation and stereotypes on gender roles which contribute to these practices.⁷⁷

Many people from various ethnicities, with a variety of cultures, live in different regions of Iran. The Constitution of Iran guarantees equal rights for every Iranian, irrespective of their ethnic or religious background. It also protects the human rights of the non-Muslims and obliges the government to treat them without discrimination.⁷⁸ The health system of Iran is community-based, respectful to the traditions and culture of people in different regions. The personnel of primary healthcare centres in rural areas are selected from local communities. They know the local traditions and are able to give health services and information in the local language. In all the development plans of Iran, improving the standard of living in disadvantaged areas is emphasized. Reports show higher rates of mortality in infants and children of some regions of Iran in which ethnic minorities live. In these regions, poor living conditions, malnutrition, limited access to safe water, poor and unhealthy sewage systems and insufficient health services exist.⁷⁹

- **Disabled Children**

Children living with disabilities around the world usually face more difficulties and barriers to the enjoyment of their rights. These barriers are not just because of their disability but due to a combination of cultural and social obstacles with which they are confronted in their daily lives. Stigmatization and discrimination make them excluded and marginalized which might even threaten their survival and development. They may be at risk of physical or mental violence and exclusion of access to education and quality healthcare and social services.⁸⁰ According to General Comment no. 7 of the CRC on the implementing child rights in early childhood, children

⁷⁶ UN Committee on the Rights of the Child. *General comment no. 11 CRC: Indigenous children and their rights under the Convention on the Rights of the Child* (CRC/C/GC/11, 2009) paras 49-52.

⁷⁷ Ibid para22.

⁷⁸ Iran Constitution, supra note 23, art 19 & 14.

⁷⁹ United Nations Economic and Social Council. *Concluding observations on the second periodic report of the Islamic Republic of Iran* (E/C.12/IRN/CO/2, 2013) 5-7.

⁸⁰ UN Committee on the Rights of the Child. *General comment no. 9 CRC: The rights of children with disabilities* (2007) paras5 & 8

with disabilities not only have the same rights as other children but also require additional assistance to exercise and enjoy their rights and to integrate into society.⁸¹

Based on the CRC, a physically, mentally or socially handicapped child has a right to a full and decent, dignified life, so (s)he should have access to the special treatment, education and care necessary for his/her condition in order to achieve the highest possible level of social integration and individual development.⁸² A disabled child has the right to access healthcare and rehabilitation services. If it is possible for states, these services should be provided free of charge, depending on the financial resources of parents, or others caring for the child.⁸³

One of the necessities, in realizing disabled children's rights, is to identify their disabilities at an early stage and to provide timely treatment and rehabilitation to achieve their full functional capacity.⁸⁴ In Iran, children are screened in several stages of their life, such as in prenatal and postnatal phases, and before attending school, to identify their probable disabilities. According to the law in Iran, preventing disabilities and social harm, and providing the facilities needed for improving the physical, mental and social conditions of the disabled are the obligations of the government.⁸⁵ Providing health, rehabilitation and social security services for vulnerable groups, such as the mentally ill, disabled and orphaned children, are parts of these obligations.⁸⁶

The Comprehensive Law on Protection of People Living with Disabilities (2004) requires the government to provide vocational and lifestyle education as well as rehabilitation services for disabled people. The government is obliged to increase the number of educational and rehabilitation centres and special institutions for the confinement of the homeless, orphaned or poverty-stricken disabled people. The government subsidizes poor families to afford homecare for disabled family members.⁸⁷ There is no study about the situation of disabled children's access to health and rehabilitation services in Iran. These services are not free for the disabled. People's large share of healthcare expenditures affects the access of the disabled to necessary services .

9.7.2 Physical Accessibility

One of the conditions of accessibility is that health facilities, services and products should be within a safe physical reach of entire population, especially marginal-

81 General comment no. 7 CRC, supra note 51, para 11b.

82 UN Declaration of the Rights of the Child 1959, Principle no. 5.

83 Convention of the Rights of the Child, supra note 15, art 23.

84 Convention on the Rights of Persons Living with Disabilities 2007, para 25.

85 The law on Structure of the Comprehensive Welfare and Social Security, supra note 73, art 4.

86 Statute of Welfare Organization of Iran 1998, art 1.

87 Comprehensive Law on Protection of People Living with Disabilities in Iran 2004, art 3-5.

ized and vulnerable groups, such as children, persons living with disabilities, ethnic minorities and indigenous populations.⁸⁸

In Iran, physical accessibility and the health needs of population are fundamental criteria for developing health services networks.⁸⁹ More than 90% of rural population and all urban population have access to primary healthcare.⁹⁰ In remote and under-developed areas of the country, the availability of medical specialist and well equipped hospitals is restricted.⁹¹ Some children who are hardest to reach, especially in disadvantaged areas, do not receive enough attention. Child deaths, malnutrition and low-weight births are higher than national average in the rural areas and lower income regions of Iran.⁹² One of the sections of the Policy Paper on the Child Development (2013) in Iran is allocated to combating regional disparities in health.. Currently, along with the programs for the improvement of urban infrastructure in disadvantaged areas, according to the Law on Health Sector Reform in Iran (2014), the government provides incentives to encourage physicians, and particularly medical specialists, to work in disadvantaged areas.⁹³ Based on General Comment no. 5 CRC on the general measures of implementation of the CRC, in addition to national laws and plans of action, states should set out time-bound and measurable provincial goals, adopt implementation measures and allocate enough financial and human resources for every individual province. Continuous monitoring and review systems should be established.⁹⁴

9.7.3 Affordability

To be accessible, health facilities, services and products, privately or publicly provided, should be affordable for all, especially for marginalized and disadvantaged groups. The principle of equity should be the basis of the payment for health services and underlying determinants of health.⁹⁵ In the World Declaration on the Survival, Protection and Development of Children (1990), eradicating poverty that would have immediate benefits for children's welfare was determined as an important step in improving survival, protection and development of children.⁹⁶ The CRC does not

88 General Comment no. 14 ICESCR, *supra* note 6 para12.

89 Rahbar, M. *supra* note 24 at 18-22.

90 Motlagh, M. Oliaimanesh, A. Beheshtian, M. *Health and social determinants of health; solution of expanding health equity and fair opportunity for all* (2nd edn, Movafagh 2008) Introduction.

91 Hamidian, Kh. *Supra* note 30 at 6.

92 WHO Regional Office for the Eastern Mediterranean, *supra* note 3 at 30.

93 The Law on Health Sector Reform in Iran 2014, art 1.

94 General comment no. 5 CRC, *supra* note 17, paras 32-35.

95 Schoukens, P. 'The right to access to health care: health care according to international and European social security law instruments' in Den Exter, A. (ed) *International Health Law: Solidarity and Justice in Health Care* (Maklu Antwerpen 2008) 22.

96 World Declaration on the Survival, Protection and Development of Children 1990, art 20 (10).

indicate that governments should improve the economic situation of families but it obliges the states to provide an adequate standard living for every child.⁹⁷ General Comment no.14 ICESCR maintains that states should provide necessary health insurance and healthcare services to poor people.⁹⁸ Providing the basic benefit pocket of insurance to everyone is one of the main policies of the universal health insurance system in Iran.⁹⁹

Generally, in Iran, apart from free primary healthcare services, access to secondary and tertiary health services for children is dependent on the kind of health insurance their parents have. In recent years, global factors, such as years of war and international isolation and sanctions, have adversely affected the wellbeing of the Iranian population, including children.¹⁰⁰ Their access to secondary and tertiary health services has declined continuously. Although more than 80% of Iranians are insured,¹⁰¹ most uninsured people are from the lowest income groups of society.¹⁰² Patient's contribution to healthcare expenditure (out of pocket) was about 60% of total health expenditure in 2011.¹⁰³ This high percentage of direct financial contribution of healthcare costs is a serious barrier for vulnerable groups of the population to access health services.

- Poor Children

Children, who are orphaned and do not have any guardian, or whose parents have inadequate, or no health insurance, might not have equal access to healthcare because of the inability to pay for the services. Iran has issued cheap packages for those who do not have any health insurance. The government offers free health insurance for the poor and their children, orphans, and prisoners.¹⁰⁴ In addition, health services and insurance are provided free of charge in rural areas. Patients with certain chronic diseases are supported with a special insurance benefit package.¹⁰⁵ However, all these programs do not completely cover all sections of population.¹⁰⁶ In recent

97 Reinbold, GW. 'Realizing Young Children's Right to Health under the Convention on the Rights of the Child' [2014] *The International Journal of Children's Rights* 22 (3) 502.

98 General Comment no. 14 ICESCR, supra note 6 para19.

99 Law on Health Services Improvement in Iran 2002, art 1.

100 UNICEF, supra note 27, at1.

101 Keshavarz, A. 'Estimating Out of Pocket payments (OOP) for medical care in Qazvin province in 2009' [2011] *Hospital* 10 (4) 75

102 Health Policy Council, Ministry of Health and Medical Education of Iran, *Health in the 5th Economic, Social, Cultural Development Plan of Iran* (Ministry of Health and Medical Education 2009) 103.

103 DaneshJafari, D. 'Financial resources of health sector' (Conference of the Review of Government's Performance in the field of Health, National Institute for Health Research, Iran 2015)

104 Directive on the Identification of Those in Need in Iran 1995, art 1; Statute of Welfare Organization, supra note 86, art1

105 Motlagh, M. Oliaimanesh, A. Beheshtian, M. supra note 90 at 87-90.

106 Hamidian, Kh. Supra note 30 at16.

years, people's contribution to health expenditure has increased considerably. The government has devised a new plan to decrease out-of-pocket payment and to cover all uninsured people by committing to pay 90% and 95% of in-patient services' costs for urban and rural populations respectively.¹⁰⁷

- *Children Living and/or Working on the Street*

There are a high number of street children, especially in large cities, with limited access to health services and education in Iran.¹⁰⁸ In recent years, the number of street children has increased considerably because of the high rate of unemployment and inflation that has worsened the living situation of poor people. Children work to make a living and help their poor families.¹⁰⁹ If their parents can not afford the rent, they become homeless too. A significant number of these children are undocumented immigrant children who, owing to the unwillingness of their parents as illegal residents of the country to be known to public organizations, have limited access to health services and education.¹¹⁰

In Iran, the By-law on Organizing Street Children (2005) includes obligations for the government to identify and empower everyone under the age of 18 living in the streets of cities, whether they have a family or not. According to this document, the health needs of street children and their families should be met; children and their families are entitled to health insurance and free health services in special health facilities. Moreover, they should be financially supported by the government until such time as their situation improves.¹¹¹

9.7.4 Information Accessibility

The right to seek, receive and impart information and ideas concerning health issues is another dimension of the accessibility of health facilities, services and products.¹¹² Based on the Executive Directive on Providing, Maintaining and Promoting the Physical, Mental, and Social Health of Students in Iran (2005), 42 hours of health education per school year should be provided to students.¹¹³ According to the Program of Health Promoter Schools, this education should be about a healthy lifestyle,

107 Directive on the Budget Allocation for Health System Reform 2014, art1-2.

108 United Nations, Economic and Social Council, *supra* note 79 at 5.

109 International Campaign for human rights in Iran, *A Growing Crisis: The Impact of Sanctions and Regime Policies on Iranians' Economic and Social Rights* (vol 1, International Campaign for human rights in Iran 2013) 14.

110 UNICEF, *supra* note 27 at 22.

111 Bylaw on Organizing Street Children in Iran 2005, art2.

112 General Comment no. 14 ICESCR, *supra* note 6, para 12 (b).

113 Directive on Providing, Maintaining and Promoting the Physical, Mental, Social Health of Students in Iran 2005, art1-2.

especially healthy and nutritious food.¹¹⁴ Health education, especially about young children's health, is one of the services provided by the PHC of Iran.

According to the CRC, in making decisions on a child's health, (s)he should have the opportunity to participate, receive appropriate information, and counselling, negotiate about his/her choices and freely express views in accordance with his/her age and maturity.¹¹⁵ Access to confidential counselling, without parental or legal guardian's consent, should be provided to adolescents if professionals working with them think it is in their best interest.¹¹⁶ In Iran, there is no law or policy about these rights of children. Married girls face another limitation in access to health services. It is common in Iran that married girls and women need to get the consent of their spouse to receive hospital care and surgery.¹¹⁷ Particularly, the husband's consent is a prerequisite to access some health services such as abortion, C-Section, infertility treatment, hysterectomy, sex reassignment surgery, organ transplant and cosmetic surgery.¹¹⁸ These girls are considered mature enough to get married but not to decide independently about their body.

9.8 CONCLUSION

In Iran, the constitution and health laws guarantee equity in access to healthcare for all. In spite of the overall gains, and having several national laws for the protection of vulnerable groups of children, in practice, access of all children to health services is not equal. Children who are living in poverty, children of illegal immigrants, children without identity or birth certificate, children living in remote areas and married girls face difficulties in accessing health services in Iran. In some of these cases, law is the source of discrimination and restricts access to the services. The law that guarantees equal access to healthcare but requires payment for the services falls short in taking measures to overcome discrimination against poor people. The law on issuing birth and identity certificates restricts the access of children who are borne out of wedlock or from illegal immigrants to necessary services, including healthcare and insurance. All children must be provided with a birth certificate at the time of birth.

114 Health Policy Council MOHME, *supra* note 2 at 284.

115 Convention on the Rights of the Child, *supra* note 15, art 12 & 13.

116 UN Committee on the Rights of the Child. *General comment No. 15 CRC the right of the child to the enjoyment of the highest attainable standard of health* (2013) para 31.

117 Rahimi, H. Sadeghi, H. Amaini Samani, R. 'The consent of the husband for health care services of the wife' [2012] Private Law 8(18) 25.

118 Mahmudian, S. Arzamani, M. Dolatabadi, T. *Consent and its Legal Aspects* (North Khorasan, Bojnord, Iran 2007) 15- 21

Regarding the law on the provision of free health insurance for poor people and their children, incomplete implementation is a problem. There is no comprehensive data system regarding the situation of children and a monitoring system to measure the implementation of the laws concerning children. In other cases, such as for protecting street children, the corresponding programs and infrastructure have not been adopted. Sufficient budget allocation, especially for vulnerable children, a data system on the situation of children and a monitoring system to track the progress of related programs are needed. Iran must amend the law on children's marriage and remove barriers that married girls face in access to health services, such as the obligatory consent of the husband. Married girls with poor living situations should get financial support, since they are more likely to be uneducated and unemployed, and have limited financial resources to access the necessities of life. Special attention should be paid to the health of adolescents and their access to sexual health and family planning information and services at schools and health facilities. Iran should employ the necessary means to remove the disparities in the health status of children living in different provinces, particularly those of indigenous and ethnic minorities. Children of poor illegal immigrants should have access to health services in emergencies, irrespective of the legal status of their parents. Financial and physical accessibility of health and rehabilitation services should be guaranteed for children living with disabilities. To access necessary health services, children should not face any financial limitations; their unconditional access should be guaranteed.

The PHC system in Iran has provided equal access to primary health services, but its focus is more on the prevention of diseases. Based on the principle of progressive realization, the government of Iran should provide equal access to advanced health services too. Programs in the pilot stage, such as the Program on the Health of Adolescents, should be implemented to a larger extent. Analysing the accessibility of health services in Iran shows that the main problems concerning access to healthcare are unaffordability of health services and a shortage of health professionals in remote and rural areas. Iran should allocate scarce healthcare resources in a way to meet the basic needs of all people. The gaps in the fulfilment of the rights of children should be identified and access barriers should be eliminated. Failure to eliminate differential treatment and progressively realizing children's rights, on the basis of a shortage of resources, is not a reasonable justification. It is an international principle on children's rights that, in all circumstances, children should be among those who receive protection and relief first.¹¹⁹

To promote the health of children, their needs and rights should be a priority in all development plans of Iran. The future policies of Iran should, first and foremost,

119 UN Declaration of the Rights of the Child 1959, art8.

ensure the minimum of subsistence rights for all and safeguard children from inadequate protection or rights violations, then progressively improve the situation of all children by using the maximum extent of available resources. To properly implement CRC, Iran should strengthen the co-ordination among various government bodies involved in children's rights at national and international level. Society should have sufficient information and be able to identify vulnerable children in need.¹²⁰ Children should be aware of their enforceable rights. Health workers, in the public and private sectors, should be trained about children's rights and there should be deterrent sanctions against those who violate children's right to equal access to healthcare.¹²¹

Finally, since all human rights are interdependent and interrelated, policies about the right to health should be prepared as a part of a comprehensive plan concerning children's welfare. Policies should entail the right to underlying determinants of health such as food, education and housing too. According to the World Fit for Children 2002, to build a world fit for children, principles, such as putting children first, eradicating poverty, caring for every child, not leaving any child behind, educating children, protecting children from harm, exploitation and war, listening to children, ensuring their participation in the decisions related to them and protecting the earth for them should be addressed in the policies of governments.¹²²

120 United Nations Economic and Social Council. Supra note 79 at 11-17.

121 General Comment no. 20 ICESCR, supra note 45, para36.

122 UN General Assembly. *Resolution no. S-27/2, A World Fit for Children* (A/RES/S-27/2; 2002) para7.

PART V

General Concluding Observations and Recommendations

INTRODUCTION

In the previous chapters, the right to health and the obligations of states regarding this right have been discussed. Several international and regional human rights laws recognise this right. To realize human rights including the right to health, international laws should be implemented at domestic level. In addition, to improve the realisation of rights, countries' conduct should be assessed. Iran has been chosen for this case study. In chapters 4-9, the situation of the right to health in the laws and practice of this country has been analysed. Chapters 4 and 5 described Iran's health system and laws with respect to the right to health. Chapter 6 addressed the right to sexual and reproductive health which is an important part of the right to health. In chapters 7-9, the situation of the right to health and its underlying determinants among two groups of population (women and children) were discussed.

The next chapter includes concluding observations and recommendations. In this chapter, Iran's conduct with respect to the realisation of the right to health is evaluated by using a conceptual framework suggested by the Office of the United Nations High Commissioner for Human Rights (OHCHR) for evaluating states' conduct, and the findings of previous chapters. This framework has three main parts: structure, process and outcome. In this chapter, the conduct of Iran is analysed and recommendations for improving the situation of the right to health in this country are provided.



Chapter 10

General Concluding Observations and Recommendations

SUMMARY

There is a universal consensus that the right to health is a fundamental human right and a prerequisite to an adequate standard of living. At the international and national levels, multiple obligations are defined for states to realize this right. In Iran, the right to health is guaranteed in the Constitution, and national laws and policies. The objective of this research is to gain insight into international and Iran's legal provisions related to the right to health and the actual situation of this right in Iran. The questions of this study concern whether the current means for protection of the right to health are sufficient in Iran, what the gaps and barriers to equal enjoyment of the right to health are and how those gaps and barriers can be removed.

To answer these questions, a qualitative case study involving a structured document review of international and Iran's laws and policy documents on the right to health, and the academic literature addressing the situation of Iranians' enjoyment of the right to health and its underlying determinants was undertaken. Different human rights assessment tools were used to evaluate the country's conduct in realizing the right to health. In Chapter 1 of the study, background information, including the objectives, questions and methods of the study, is explained. The first step in performing such an assessment is to understand the subject of the assessment—here, the right to health. Chapters 2-3 of the study are devoted to introducing the basic concepts and principles of human rights as well as the right to health and related state obligations. Because of the importance of the justiciability of the right to health in the proper realization of this right, different views for and against this characteristic of the right to health in the academic literature and legal provisions are discussed in this chapter. The question in this part of the study is whether the right to health is justiciable based on the normative content of this right and international human rights provisions. A review of the literature, legal documents and case law indicates that the right to health is substantially a justiciable right. States have the inevitable duty to guarantee at least the minimum necessities for everyone's health and to use all necessary administrative, legal, financial and judicial means to realize this right. After clarifying the right to health and states' obligations, the status of this right in the laws and practice of Iran is scrutinized.

In Chapter 4, after providing a review of the political, demographic and socio-economic situation of Iran and different aspects of the health system of this country, national laws and policies related to the right to health are analyzed. This chapter continues with a situation analysis of the right to health and its underlying determinants in Iran in Chapter 5. In the first two decades after the Islamic Revolution of 1979 in Iran, this country had a respectable record of improving the health of its population and access to healthcare facilities, services and products. However, in

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recent years, international isolation and economic sanctions and the country's inappropriate resource management have significantly and adversely affected the welfare of Iran's population. The increase in the poor population, particularly among women and children, and their limited access to the necessities of life, such as nutritious food and medical care, necessitates new policies and immediate actions for improving Iranians' standard of living. This study showed that the international economic sanctions against Iran affected the health of people in two ways. First, by decreasing the country's industrial production, revenues, and the value of national currency, they increased unemployment and inflation, which have deteriorated the general welfare of people. In this situation, some groups of the population could not afford nutritious food and healthcare. Second, placing limitations on shipments and banking and financial services made it difficult to import medicines, medical equipment and food. The limitations endangered the health and lives of people, particularly of patients and children.

A necessary principle for realizing the right to health is considering this right in all the development plans, laws and policies of states. Chapter 6 discusses new population policies of Iran which contain limitations on access to family planning services and contraceptives, and incentives for having more children. Some elements of these policies are in contrast with the standards of international human rights treaties concerning the right to health, including the prohibition on placing limitations on access to sexual and reproductive health services and taking retrogressive measures in the realization of rights. Before changing policies that directly and indirectly affect people's health, such as population policies in Iran, their probable adverse effects should be predicted and necessary measures adopted to prevent them. Iran's new policy can threaten public health by increasing unwanted pregnancies, induced abortions, sexually transmitted diseases, the incidence of HIV infection, and pregnancy-related illnesses and death. This study suggests that Iran should revoke these laws and policies and improve people's enjoyment of their right to sexual and reproductive health. Instead of limiting people's access to family planning, this country should focus on encouraging people to have higher fertility by supporting parents and future children.

Another important principle in the realization of the right to health is the principal of advancing equality. A review of the Constitution, laws and policies of Iran shows that promoting equality in the enjoyment of basic rights is one of the important aims of this country. However, some vulnerable groups of the Iranian population, such as people living in informal urban settlements and remote rural areas, old people, drug addicts, poor children and women and people living with disabilities, might not have equal access to the necessities of life, including medical care, and might require special support. All groups whose enjoyment and exercise of their rights are limited

should receive aid. Chapters 7-9 of the study are devoted to a situational analysis of women's and children's right to health in Iran.

The health of Iranian children in early childhood has improved considerably in recent years, but attention to the health needs of children in other stages of their lifespan, including adolescence, has not been sufficient. Provision of youth-friendly health services and age-appropriate health education as well as promotion of responsible behavior among adolescents are necessary. Examples of disadvantaged and vulnerable groups of children living in Iran include children of poor families, children without an identity, children born out of wedlock, children of illegal immigrants and children living with disabilities. Current programs to support children lack appropriate identification measures and adequate financial means for the improvement of children's living situation. Disparities in the health levels of children living in different provinces of Iran or belonging to indigenous and ethnic minorities should be removed. The future policies of Iran should initially focus on providing minimum subsistence rights for all children and protecting them from rights violations. Then, by using the maximum extent of available resources, Iran should progressively improve the situation of all children. In Iran, a comprehensive policy on the welfare of children, a data system tracking the situation of children and a monitoring system to track the progress of programs are needed. The necessary means for empowering society to identify and support children in need should be addressed. There is a need to enhance knowledge of children's rights on the part of Iranian society, parents and children. Families without adequate means to provide a proper standard of living for their children and married-, parent- and divorced-children should be supported by the government. In addition, the mental health of children has received insufficient attention in the health programs of Iran. It should be considered a priority in the future health plans of this country.

Women's rights to enjoy an adequate standard of living and achieve good health are recognized by the Constitution, Charter of the Rights and Responsibilities of Women (2004) and health laws and policies in Iran. National laws require the government to remove barriers to women's access to the necessities of life, such as healthcare. However, not all women who are eligible to receive support are covered by Iran's current social security programs. In addition, not all the provisions of the Constitution and national laws on women's rights are supported with action plans. In some cases, the law has not even defined the responsible authorities for implementing legal provisions, such as the Charter of the Rights and Responsibilities of Women in Iran. Different groups of women living in Iran might not have equal opportunities to enjoy their right to health. Examples include female heads of families, unemployed women, women without an appropriate male guardian, widows, divorced women, women living with disabilities, illegal immigrant and indigenous women, women

belonging to ethnic and religious minorities, elderly women, street women, rural women, and poor women. Along with removing the disparities in health status and access to health services, empowering women and providing them opportunities to work and participate in society will help them enjoy their rights.

In addition to the barriers that both men and women may face when attempting to access healthcare, such as the inability to pay for the services, women face another barrier, which is the consent of their male guardian. Having a male guardian can be an advantage for poor women to overcome financial barriers to access healthcare because the guardian bears the responsibility for paying the costs of services. However, Iranian law gives men the right to interfere in their wife's enjoyment of her rights to access some health services, such as an abortion, a C-section or an organ transplant. The role of the male guardian in the access of women to healthcare needs to be reviewed. Everyone is entitled to an equal opportunity to exercise his/her rights and access health services. The right to health cannot be conditional. Moreover, women are fully capable adults who are able to make responsible decisions concerning their health and lives and they have a right to autonomy and control of their bodies; they do not need a guardian. Iran's government should identify and remove all barriers in the law and the cultural attitudes of the population that hinder women's access to health services and social security. Women's rights should be guaranteed regardless of their marital status.

Chapter 10 of the study assesses the health system of Iran in terms of the realization of the right to health by using the conceptual framework suggested by the Office of the United Nations High Commissioner for Human Rights, which is a structural, process and outcome assessment using AAAQ criteria introduced by General Comment no.14 ICESCR. The structural part concerns the ratification of international human rights treaties. Iran has ratified most international treaties but, in particular, not the Convention on the Elimination of all Forms of Discrimination against Women. However, the provisions of this convention concerning women's right to health are considered in Iran's laws. The process part is related to the incorporation of international standards into domestic laws and policies. A review of Iran's laws and practice indicate that the government intends to move forward in the realization of the right to health. The Outcome captures the actual realization of the right to health. In recent years, Iran has made considerable achievements in improving its population's main health indicators. However, there are disparities in the health level of citizens of under-developed provinces that should be removed.

The availability and acceptability of health services, products and facilities in Iran are acceptable. Moreover, physical access to primary healthcare (PHC) facilities is satisfactory, but a few rural areas do not have access to these facilities. The number of secondary and tertiary health facilities is also sufficient. However, they are not

distributed equally throughout the country. Furthermore, access to PHC information is acceptable; however, opportunities to acquire health information at the level of advanced and hospital care are not sufficient. In addition, the quality of PHC services is acceptable, but the quality of hospital care needs improvement. With respect to the affordability of health services, although Iran has promoted universal health insurance, made plans for supporting the poor, attempted to keep hospital service fees as low as possible and increased its share of health services costs, healthcare is not affordable for the poorest proportion of the population. Iran's health system lacks an efficient referral system and suffers from an excessive use of services resulting from induced demand and a lack of clinical guidelines. Moreover, the consumption of subsidized health services is not regulated. This situation has increased people's actual share of health service costs. Maintaining an under-resourced health network, when human and financial resources are pulled into vertical programs, pushes the health system to the point of collapse.

Epidemiologic and demographic transitions and the growing burden of chronic diseases require the immediate establishment of Family Doctors Program throughout the country. To improve the realization of people's right to health, this country should change its priorities in regard to the allocation of health system resources from excessive spending on advanced health services to health prevention and protection services, which are beneficial for a larger proportion of the population. Removing existing inequities in the distribution of health sector resources and facilities and bringing disadvantaged groups up to mainstream levels are necessary. Policies on improving the health of the population should be part of a comprehensive plan on the welfare of the population and the empowerment of vulnerable groups. In addition, the government should implement appropriate measures to protect the health of citizens. Insufficient control of the agricultural sector, food industry, sanitation in cities, health of the environment, and vanishing drinking water resources endangers the health of Iranians. Not regulating private parties' conduct and inspecting and monitoring their compliance and not enforcing administrative and judicial sanctions against non-compliant third parties, such as potentially polluting industries or food and water suppliers, are violations of the right to health.

Finally, Iran has weaknesses in the implementation of health laws and policies related to improving the living standards and health of the population, including incomplete implementation, a lack of corresponding programs and provincial action plans, and unclear methods and processes of implementation and financing. Iran's programs on the welfare of the population are very often scattered and short term in nature. A change in the government or provincial authorities might stop the implementation of a long-term plan. The establishment of a data system concerning the health situation of the population and a monitoring system to control the implemen-

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tation of related laws are necessary in Iran. It is crucial to provide appropriate means for ensuring governmental transparency and accountability related to the healthcare and welfare policies and to provide remedies and redress for every individual or group whose rights are violated.

NEDERLANDSE SAMENVATTING

Men is het er algemeen over eens dat het recht op gezondheid een grondrecht en een voorwaarde voor een adequate levensstandaard is. Op internationaal en nationaal niveau zijn en worden diverse verplichtingen vastgesteld waaraan een staat moet voldoen om dit recht te verwezenlijken. In Iran wordt het recht op gezondheid gewaarborgd in de grondwet, de nationale wetgeving en het beleid van het land. Het doel van dit onderzoek is inzicht te verkrijgen in de wettelijke bepalingen betreffende het recht op gezondheid, zowel internationale als van Iran, en de werkelijke situatie met betrekking tot dit recht in Iran. Dit onderzoek tracht een antwoord te geven op de vragen of de huidige middelen voor bescherming van het recht op gezondheid in Iran voldoende zijn, wat de lacunes en belemmeringen voor het gelijke genot van het recht op gezondheid zijn, en hoe deze lacunes en belemmeringen kunnen worden aangepakt.

Om deze vragen te beantwoorden, is een kwalitatieve casestudy uitgevoerd in de vorm van een gestructureerde beoordeling van internationale en Iraanse wetten en beleidsdocumenten inzake het recht op gezondheid, wetenschappelijke literatuur over de situatie rond het genot van het recht op gezondheid in Iran en de bepalende elementen daarin. Om het gedrag van het land bij het verwezenlijken van het recht op gezondheid te evalueren zijn verschillende instrumenten voor de beoordeling van mensenrechten gebruikt. In hoofdstuk 1 van de thesis wordt achtergrondinformatie gegeven, in het bijzonder over de doelstellingen, vragen en methoden van het onderzoek. De eerste stap in de bovengenoemde beoordeling is inzicht krijgen in het voorwerp van de beoordeling, in dit geval het recht op gezondheid. Hoofdstuk 3 van de thesis is een inleiding op de basisbegrippen en beginselen van mensenrechten en het recht op gezondheid en de daarmee verband houdende verplichtingen van de staat. Omdat het voor een goede verwezenlijking van het recht op gezondheid van belang is dat dit recht wettelijk kan worden afgedwongen, worden in dit hoofdstuk verschillende standpunten voor en tegen de afdwingbaarheid van dit recht in de wetenschappelijke literatuur en de wettelijke bepalingen besproken. De vraag in dit deel van de thesis is of het recht op gezondheid kan worden afgedwongen op basis van de normatieve inhoud van het recht op gezondheid en de bestaande internationale wettelijke mensenrechtenbepalingen. Een onderzoek van literatuur, juridische documenten en jurisprudentie geeft aan dat het recht op gezondheid in wezen in rechte afdwingbaar is. Staten hebben de onontkoombare plicht om ten minste de basisbehoeften voor ieders gezondheid te waarborgen en om alle noodzakelijke bestuurlijke, juridische, financiële en justitiële middelen aan te wenden om dit recht te verwezenlijken. Nadat het recht op gezondheid en de verplichtingen van staten

zijn toegelicht, wordt de situatie rond dit recht in de wetten en praktijken in Iran onder de loep genomen.

In hoofdstuk 4 wordt eerst een overzicht gegeven van de politieke, demografische en socio-economische situatie in Iran en verschillende aspecten van het gezondheidsstelsel in het land. Daarna worden de nationale wetgeving en het beleid inzake het recht op gezondheid geanalyseerd. Vervolgens wordt in dit hoofdstuk de situatie met betrekking tot het recht op gezondheid en zijn bepalende elementen in Iran geanalyseerd. In de eerste twintig jaar na de Islamitische Revolutie van 1979 in Iran had het land een respectabele staat van dienst waar het ging om verbetering van de volksgezondheid en de toegang tot gezondheidszorgfaciliteiten, -diensten en -producten. In recente jaren hebben de internationale isolatie en de economische sancties, alsook het onjuiste beheer van de middelen van het land het welzijn van de Iraanse bevolking zeer negatief beïnvloed. De toename van armoede onder de bevolking, in het bijzonder onder vrouwen en kinderen, en de beperkte toegang van de armen tot eerste levensbehoeften zoals voedzame levensmiddelen en medische zorg vragen om nieuw beleid en onmiddellijke acties om de levensstandaard van de Iraniërs te verbeteren. Dit onderzoek heeft bevestigd dat de internationale economische sancties tegen Iran de gezondheid van mensen op twee manieren hebben beïnvloed. Op de eerste plaats zijn door de sancties de industriële productie, de inkomsten en de waarde van de nationale munteenheid van het land gedaald en zijn de werkloosheid en inflatie gestegen, waardoor de algemene welvaart van de bevolking is afgenomen. In deze situatie kunnen sommige bevolkingsgroepen zich geen voedzame levensmiddelen en gezondheidszorg meer veroorloven. Op de tweede plaats leggen de sancties beperkingen op aan vervoers-, bank- en financiële diensten, wat de invoer van geneesmiddelen, medische apparatuur en levensmiddelen bemoeilijkt. Dit heeft de gezondheid en het leven van mensen, in het bijzonder van patiënten en kinderen, in gevaar gebracht.

Een noodzakelijk beginsel voor het verwezenlijken van het recht op gezondheid is dat in alle ontwikkelingsplannen, wetten en beleidsmaatregelen van staten rekening wordt gehouden met dit recht. Het nieuwe bevolkingsbeleid van Iran bevat beperkingen aan de toegang tot gezinsplanningsdiensten en voorbehoedsmiddelen, alsook stimulansen om meer kinderen te krijgen. Sommige elementen van dit beleid zijn in strijd met de normen inzake het recht op gezondheid in internationale mensenrechtenverdragen, met inbegrip van het verbod om de toegang tot seksuele en reproductieve gezondheidsdiensten te beperken en retrogressieve maatregelen te nemen bij de verwezenlijking van rechten. Voordat beleid dat de gezondheid van mensen direct of indirect beïnvloedt, zoals het bevolkingsbeleid van Iran, werd gewijzigd, hadden de waarschijnlijke negatieve effecten van het nieuwe beleid moeten worden voorzien en hadden de benodigde maatregelen moeten worden genomen om deze

effecten te voorkomen. Het nieuwe beleid van Iran kan een gevaar voor de volksgezondheid vormen doordat het aantal ongewenste zwangerschappen, afbrekingen van zwangerschappen, seksueel overdraagbare aandoeningen, nieuwe gevallen van hiv-besmetting en zwangerschapsgerelateerde ziekte- en sterfgevallen door dit beleid zal toenemen. In deze thesis wordt aangevoerd dat Iran deze wetgeving en dit beleid zou moeten herroepen en het genot van het recht op seksuele en reproductieve gezondheid voor mensen zou moeten verbeteren. In plaats van de toegang tot gezinsplanning te beperken, zou het land zich erop moeten richten mensen aan te moedigen om meer kinderen te krijgen door ouders en toekomstige kinderen te ondersteunen.

Een ander belangrijk beginsel voor het verwezenlijken van het recht op gezondheid is de bevordering van gelijkheid. Uit een onderzoek van de grondwet, de wetgeving en het beleid van Iran komt naar voren dat bevordering van het genot van grondrechten een belangrijk streefdoel van het land is. Sommige kwetsbare bevolkingsgroepen in Iran, zoals mensen die in informele stedelijke nederzettingen en afgelegen plattelandsgebieden leven, ouderen, drugsverslaafden, arme kinderen en vrouwen en mensen met een beperking, hebben mogelijk echter geen gelijke toegang tot de zaken die noodzakelijk zijn voor een adequate levensstandaard, waaronder medische zorg, en zij hebben speciale ondersteuning nodig. Om gezondheid voor iedereen te bevorderen, zouden de groepen die bij het genot en de uitoefening van hun rechten te maken hebben met beperkingen, ondersteuning moeten krijgen. Hoofdstuk 7-9 van de thesis zijn gewijd aan een analyse van de situatie met betrekking tot het recht van vrouwen en kinderen op gezondheid in Iran.

De gezondheid van Iraanse kinderen in hun allereerste levensjaren is in de afgelopen jaren aanzienlijk verbeterd, maar er is onvoldoende aandacht voor de gezondheidsbehoeften van kinderen in andere fasen van hun leven, zoals de adolescentie. Er zijn jongerenvriendelijke diensten, op de leeftijd afgestemde gezondheidsvoorlichting en bevordering van verantwoord gedrag onder adolescenten nodig. Voorbeelden van kansarme en kwetsbare groepen kinderen in Iran zijn kinderen in arme families, kinderen zonder identiteit, buitenechtelijke kinderen, kinderen van illegale immigranten en kinderen met een beperking. Het ontbreekt huidige programma's ter ondersteuning van aan passende maatregelen om hulpbehoevende kinderen te herkennen. Ook beschikken zij over onvoldoende financiële middelen om de situatie voor deze kinderen te kunnen verbeteren. De ongelijkheid in het gezondheidsniveau van kinderen die in verschillende provincies van Iran leven of tot etnische minderheden behoren, zou moeten worden weggenomen. Het toekomstige beleid van Iran zou erop gericht moeten zijn om eerst voor alle kinderen het recht op de basisbehoeften te waarborgen en hen te beschermen tegen schendingen van hun rechten, en het zou daarna de beschikbare middelen volledig moeten aanwenden om de situatie van alle kinderen progressief te verbeteren. Iran heeft een veelomvattend beleid inzake het

welzijn van kinderen nodig, met een datasysteem voor de situatie van kinderen en een monitoringsysteem om de voortgang van programma's te volgen. Alle benodigde middelen moeten worden ingezet om de maatschappij in staat te stellen kinderen te identificeren en te ondersteunen. De kennis van kinderrechten in de Iraanse maatschappij in het algemeen en onder ouders en kinderen in het bijzonder moet worden vergroot. Families zonder toereikende middelen om hun kinderen een adequate levensstandaard te bieden, alsook gescheiden ouders met kinderen zouden door de overheid moeten worden ondersteund. Ook de geestelijke gezondheid van kinderen krijgt onvoldoende aandacht in de gezondheidsprogramma's van Iran. Deze zou in de toekomstige gezondheidsplannen van het land prioriteit moeten krijgen.

De rechten van vrouwen om een adequate levensstandaard te genieten en de hoogst haalbare standaard van geestelijke en lichamelijke gezondheid te bereiken worden in Iran in de grondwet, in het Handvest van de rechten en verantwoordelijkheden van vrouwen en in de wetgeving en het beleid inzake gezondheid erkend. Nationale wetten verplichten de regering om belemmeringen voor de toegang van vrouwen tot de noodzakelijkheden voor een adequate levensstandaard, zoals gezondheidszorg, weg te nemen. Niet alle vrouwen die voor ondersteuning in aanmerking komen, vallen echter onder de huidige socialezekerheidsprogramma's van Iran. Ook worden niet alle bepalingen van de grondwet en de nationale wetgeving inzake de rechten van vrouwen ondersteund door actieplannen. In sommige gevallen is in de wet zelfs niet vastgelegd welke autoriteiten verantwoordelijk zijn voor de tenuitvoerlegging van de wettelijke bepalingen, zoals in geval van het Handvest van de rechten en verantwoordelijkheden van vrouwen in Iran. Verschillende groepen vrouwen in Iran hebben mogelijk geen gelijke kansen om hun recht op gezondheid uit te oefenen. Voorbeelden daarvan zijn vrouwelijke gezinshoofden, werkloze vrouwen, vrouwen zonder passende mannelijke voogd, weduwen, gescheiden vrouwen, vrouwen met een beperking, illegale immigrantenvrouwen vrouwen die tot etnische en religieuze minderheden behoren, oudere vrouwen, dakloze vrouwen, plattelandsvrouwen en arme vrouwen. Behalve het wegnemen van ongelijkheden, zullen ook 'empowerment' van vrouwen en het bieden van kansen aan vrouwen om te werken en te participeren in de maatschappij vrouwen helpen om hun rechten uit te oefenen.

Naast de belemmeringen die zowel mannen als vrouwen kunnen ervaren wanneer zij toegang willen krijgen tot gezondheidszorg, zoals onvermogen om voor de diensten te betalen, hebben vrouwen ook nog met een andere belemmering te maken, namelijk de toestemming van hun mannelijke voogd. Het hebben van een mannelijke voogd kan voor arme vrouwen een voordeel zijn om financiële belemmeringen voor de toegang tot gezondheidszorg te overwinnen, omdat de voogd verantwoordelijk is voor betaling van de kosten van diensten. De Iraanse wet geeft hem echter het recht om zich te mengen in zijn vrouws uitoefening van haar rechten

op toegang tot bepaalde gezondheidsdiensten, zoals abortus provocatus, keizersnede of orgaantransplantatie. De rol van de mannelijke voogd in de toegang van vrouwen tot gezondheidszorg moet worden herzien. Iedereen heeft recht op gelijke kansen om zijn of haar rechten op en toegang tot gezondheidsdiensten uit te oefenen. Aan het recht op gezondheid kunnen geen voorwaarden worden verbonden. Vrouwen zijn bovendien volstrekt capabele volwassenen die in staat zijn om zelf verantwoorde beslissingen over hun gezondheid en leven te nemen en recht op autonomie en controle over hun eigen lichaam hebben; ze hebben geen voogd nodig. De overheid van Iran zou alle belemmeringen in de wetgeving en culturele houdingen van de bevolking die de toegang van vrouwen tot gezondheidsdiensten en sociale zekerheid hinderen, moeten identificeren en wegnemen. De rechten van vrouwen zouden moeten worden gewaarborgd ongeacht hun burgerlijke staat.

Hoofdstuk 10 van de thesis bevat een beoordeling van het gezondheidsstelsel van Iran op het vlak van de verwezenlijking van het recht op gezondheid. Deze beoordeling is uitgevoerd door toepassing van het conceptuele kader zoals dat is voorgesteld door het VN-Bureau van de Hoge Commissaris voor de Rechten van de Mens, dat een structuur-, proces- en uitkomstenbeoordeling is, en het kader van beschikbaarheid, toegankelijkheid, aanvaardbaarheid en kwaliteit dat is geïntroduceerd door General Comment nr. 14 bij het Internationaal Verdrag inzake economische, sociale en culturele rechten van de VN. Het structuurgedeelte betreft de ratificatie van internationale mensenrechtenverdragen. Iran heeft de meeste verdragen wel geratificeerd, maar met name niet het Verdrag inzake de uitbanning van alle vormen van discriminatie van vrouwen. In de wetgeving van Iran wordt echter wel rekening gehouden met de bepalingen betreffende het recht van vrouwen op gezondheid in dit verdrag. Het procesgedeelte betreft de integratie van internationale normen in de nationale wetgeving en beleidslijnen. De beoordeling van de wetgeving en praktijk van Iran wijst uit dat de overheid van plan is om door te gaan met de verwezenlijking van het recht op gezondheid. Het uitkomstengedeelte betreft de daadwerkelijke verwezenlijking van het recht op gezondheid. In de afgelopen jaren heeft Iran aanzienlijke resultaten geboekt in de verbetering van de belangrijkste gezondheidsindicatoren van de bevolking. Er zijn echter nog steeds verschillen in het gezondheidsniveau van burgers, en de achterstand van onderontwikkelde provincies op dit vlak moet worden aangepakt.

De beschikbaarheid en aanvaardbaarheid van gezondheidsdiensten, -producten en -faciliteiten in Iran is bevredigend. Ook de fysieke toegang tot faciliteiten voor eerstelijnsgezondheidszorg is bevredigend. Een zeer klein aantal plattelandsgebieden heeft echter nog geen toegang tot zulke voorzieningen. Het aantal faciliteiten voor tweedelijns- en derdelijnsgezondheidszorg is eveneens bevredigend, maar deze faciliteiten zijn niet gelijkmatig over het hele land verdeeld. Voorts is de toegang tot informatie over eerstelijnsgezondheidszorg aanvaardbaar; de mogelijkheden

om gezondheidsinformatie op het niveau van medisch specialistische zorg en ziekenhuiszorg te verkrijgen zijn echter onvoldoende. Daarbij is de kwaliteit van de eerstelijnsgezondheidszorgdiensten aanvaardbaar, maar heeft de kwaliteit van de ziekenhuiszorg verbetering. Wat betreft de betaalbaarheid van gezondheidsdiensten, is gezondheidszorg niet betaalbaar voor het armste deel van de bevolking, ook al heeft Iran een algemene ziektekostenverzekering gepromoot, plannen gemaakt voor ondersteuning van de armen, geprobeerd de tarieven van ziekenhuisdiensten zo laag mogelijk te houden en zijn aandeel in de kosten van gezondheidsdiensten vergroot. Het gezondheidsstelsel van Iran heeft geen efficiënt verwijzingssysteem en kampt met een overmatig gebruik van diensten als gevolg van een door het aanbod veroorzaakte vraag en het ontbreken van klinische richtsnoeren, terwijl het gebruik van gesubsidieerde gezondheidsdiensten niet wordt gereguleerd. Door deze situatie is de feitelijke bijdrage van de burgers in de kosten van gezondheidsdiensten gestegen. De instandhouding van een onderbezet gezondheidsnetwerk, terwijl personele en financiële middelen naar verticale programma's worden getrokken, heeft ertoe geleid dat het gezondheidsstelsel het punt van instorten nadert.

De epidemiologische en demografische transitie en het groeiende aantal chronische ziekten maken het noodzakelijk dat onmiddellijk in het hele land huisartsgeneeskunde wordt opgezet. Om de verwezenlijking van het recht op gezondheid van mensen te verbeteren zou het land de prioriteiten in de toewijzing van middelen voor het gezondheidsstelsel moeten verleggen van buitensporige uitgaven voor geavanceerde gezondheidsdiensten naar diensten voor preventie en gezondheidsbescherming die nuttig zijn voor een groter deel van de bevolking. De bestaande ongelijkheden in de verdeling van de middelen en faciliteiten in de gezondheidssector moeten worden aangepakt en de positie van kansarme groepen moet op een gemiddeld niveau worden gebracht. Het beleid inzake verbetering van de volksgezondheid zou deel moeten uitmaken van een veelomvattend plan voor het welzijn van de bevolking en de versterking van de positie van kwetsbare groepen. Bovendien vormen onvoldoende controle op de agrarische sector, de voedingsmiddelenindustrie, de sanitaire voorzieningen in steden, de gezondheid van het leefmilieu, en opdrogende drinkwaterbronnen een gevaar voor de gezondheid van Iraniërs; de overheid moet passende maatregelen ten uitvoer leggen om de gezondheid van burgers te beschermen. Het niet reguleren van het gedrag van private partijen, het niet inspecteren en monitoren van hun naleving van de wet, het niet ten uitvoer leggen van bestuurlijke en gerechtelijke sancties die worden opgelegd aan derden die de wet niet naleven, zoals mogelijk vervuilende industrieën of leveranciers van voedingsmiddelen en water, zijn een schending van het recht op gezondheid.

In Iran is er sprake van een zwakke tenuitvoerlegging van de wetgeving en het beleid inzake gezondheid, met inbegrip van onvolledige tenuitvoerlegging, het

ontbreken van bijbehorende programma's en provinciale actieplannen, en onduidelijke methoden en procedures voor uitvoering en financiering. De plannen van Iran om de levensstandaard en gezondheid van de bevolking te verbeteren zijn erg vaak versnipperd en periodiek van aard. Een regeringswisseling of een verandering bij provinciale autoriteiten kan leiden tot beëindiging van de tenuitvoerlegging van een langetermijnplan. Er zouden in Iran een datasysteem voor de gezondheidssituatie van de bevolking en een monitoringsysteem om de tenuitvoerlegging van de daarop betrekking hebbende wetten te controleren moeten worden opgezet. Het is van essentieel belang dat passende middelen worden verschaft om de transparantie en verantwoordingsplicht van de overheid te waarborgen en om ieder individu en iedere groep van individuen van wie de rechten worden geschonden, beroeps- en compensatiemogelijkheden te bieden.



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CURRICULUM VITAE

Fatemeh Kokabisaghi holds a bachelor and master degree in Health Services Management from Tehran University of Medical Sciences, Iran. Prior to her doctorate research, for some years, she has worked on the National Health Sector Reform Project of the Ministry of Health and Medical Education of Iran. In Recent years, she has focused on the legal aspects of the right to health. Her PhD research at the Erasmus School of Health Policy and Management of Erasmus University Rotterdam focuses on the domestic implementation of international laws related to the right to health. Since 2016, she has been a lecturer at the Health Faculty of Mashhad University of Health Sciences of Iran too. Alongside her PhD research, Fatemeh has taught various courses on health policies and laws. In addition, she has followed various courses on human rights and given presentations and workshops about her PhD research in national and international events. She has published several articles about health sector reform, right to health, rights of vulnerable groups including children and women, and development policies. Moreover, she is an Associate Editor and Reviewer for several academic journals. One of her publications entitled “Right to Sexual and Reproductive Health in New Population Policies of Iran” published in the Journal of Public Health Policy in 2017 has been shortlisted for the PhD Excellence Award by the Graduate School of Erasmus University Rotterdam.

In 2018, her article entitled “the Role of Male Guardians in Women’s Access to Health Services” that was published in the International Journal of Law, Policy and the Family won the Award for the best article.

ACADEMIC RECORD OF FATEMEH KOKABISAGHI DURING DOCTORAL STUDIES

1. Published articles

- **Kokabisaghi, F.** ‘Women’s right to health in Iran’ [2019] International Journal of Health Planning and Management, doi:10.1002/hpm.2737
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2. Presentations

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- **Kokabisaghi, F.** Right to Health in Islam, Seminar on the Right to Health in Islam, Mashhad University of Medical Sciences, Iran 20/04/2017
- **Kokabisaghi, F.** How Telemedicine Can Promote Realization of the Right to Health? International Congress on Medical Informatics, Mashhad University of Medical Sciences, Iran 16-17/02/2017
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- **Kokabisaghi, F.** Workshop on the Right to Health in Economic Crisis, The first Conference on Administrative Reform and Organizational Innovation with a Resilient Economy Approach, Mashhad University of Medical Sciences, Iran 25-26/01/2017
- **Kokabisaghi, F.** Bakx, I. Zenelaj, B. Access to Mental Healthcare in the Digital Era, 5th Conference of the European Association of Health Law (EAHL), Prague, Czech Republic, 1–2/10/2015

3. Academic Relationships

- Member of Scientific Committee of the Conference on Administrative Reform and Organizational Innovation with a Resilient Economy Approach, Mashhad University of Medical Sciences, Iran 2017.
- Editorial Board Member of the International Journal of Health Scope
- Reviewer of the Journal of BMC Health and Human Rights
- Reviewer of the Journal of Comparative Law Review
- Reviewer of the Journal of Immigrant and Minority Health
- Reviewer of the Edorium Journal of Public Health
- Reviewer of the Journal of BMJ Open

