

ZERO DISCRIMINATION IN HEALTH CARE

Excerpt from the
UNDG Guidance Note on Human
Rights for Resident Coordinators
and UN Country Teams

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GROUP

Zero Discrimination in Health Care*

Key points and messages that the Resident Coordinator should know about the issue

- A central promise of the Sustainable Development is to ‘ensure that no one is left behind’. Discrimination in health care, while formally prohibited in national and international law, is widespread and takes many forms, adversely impacting the way health care is delivered and received. Ending discrimination in health care will be instrumental to securing progress towards universal health coverage, ending the AIDS epidemic, and meaningfully advancing human rights, including the right to health.
- As defined by international human rights law, discrimination includes any act or behaviour that has the intention or effect of impairing the enjoyment of fundamental human rights by all people on an equal footing, including their right to access health care. Discrimination is rarely linked solely to one characteristic of a person. It is often fueled by multiple factors, referred to as intersectional or compounded discrimination. Workers in health care settings also face discrimination from their employers, co-workers, and recipients of care.
- Discrimination in health care is expressed in varying forms, including physical and verbal abuse; breaches of confidentiality; barriers in accessing services as third party authorization requirements; denial of, or failure to provide adequate health care; violations of autonomy and bodily integrity; and compulsory detention. It is also expressed in terms of persistent gender-based discrimination within the health workforce, where over two-thirds are female.
- Discrimination is driven by stigma from negative stereotypes of certain populations; discriminatory and punitive laws, regulations, policies and practices; lack of information and rights literacy; as well lack of mechanisms of accountability and redress. Health systems limitations can also contribute to discrimination, including deficiencies in education and regulation, informal employment, and poor working conditions.
- States have an immediate legal obligation to address discrimination, so health system constraints including lack of resources cannot be used as justification. While States bear this primary duty, a multi-stakeholder response is needed. Communities, political, traditional and religious leaders, trade unions, health workers associations, regulatory bodies, education and training institutions, health care facilities, civil society and media have critical roles to play to stand up against discrimination.
- An example of good practice is Thailand where, following reports of people living with HIV being denied health care, the UN country team has provided technical support to the National AIDS Strategy and one of its key outcomes on reducing stigma and discrimination. Consequently, HIV-related stigma and discrimination in healthcare settings are systematically monitored, with data collected in 22 provinces. The Ministry of Public Health is rolling out an accelerated system-wide programme in collaboration with civil society, including in-person training and e-learning.
- In Malawi, the National Association of People living with and affected by AIDS (NAPHAM), in partnership with Airtel and UNAIDS is using an SMS-based reporting system for real-time monitoring of stockouts of antiretroviral medicines and TB drugs and experiences of stigma and discrimination in the health care.
- Discrimination in health care is a persistent problem that needs to be addressed both in law and in practice and for both individual users of health care and for health care workers, in line with the Shared Framework for Action on equality and non-discrimination at the heart of sustainable development, approved by the HLCP.

Relevant International Standards

- The International Covenant on Economic, Social and Cultural Rights, which guarantees the right to health among other rights, is one of many treaties that sets out prohibited grounds of discrimination. Article 2 (2) obliges each State party “to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”
- The Committee on Economic, Social and Cultural Rights and other treaty monitoring bodies, have also established various prohibited grounds for discrimination, including HIV status, gender, disability, sexual orientation and age (see, for example: General Comment No. 20: Non-discrimination in economic, social and cultural rights; 2009 (E/C.12/GC/20); General Comment No. 22, The right to sexual and reproductive health; 2016 (E/C.12/GC/22)).
- The supervisory bodies in the International Labour Organization have adopted international labour standards, founded on international human rights instruments. Specifically, Recommendation No. 200 elaborates on the right to not be discriminated against based on real or perceived HIV status, sexual orientation or belonging to a key population in all workplaces in all sectors.

Role that the Resident Coordinator and UN Country Team can play in promoting the issue

- The UN Country Team and the Resident Coordinator can play a critical role in following-up on the recommendations of the UN Inter-Agency Statement (forthcoming) to effect change on the ground.
- Eliminating intersectional discrimination in health care settings takes concerted multi-stakeholder action. The UN Country Teams can act as conveners bringing all stakeholders to the table, and allowing for meaningful involvement and participation of communities most left behind to demand an end to discrimination in healthcare.
- As UNCTs engage in reporting to human rights mechanisms and support national stakeholder engagement with the UPR or treaty monitoring bodies, these represent critical opportunities for accountability for the elimination of discrimination in health care. Intersectionality analysis of discrimination in health care could constitute an important contribution of the UN Country Team.
- Capacity building of national stakeholders to understand roles, responsibilities and to forge appropriate codes of conduct or local accountability (including redress) mechanisms for health workers and those engaged in the healthcare sector are of equal importance.
- The UNDAF represents a critical opportunity to analyze determinants of discrimination in health care, groups most affected, and capacity gaps precluding duty-bearers from acting upon this immediate legal obligation. Where available, the SWAP to health systems should include a dedicated focus to eliminating discrimination in health care, to reinforcing responsibilities and rights of health workers, and empowering and protecting them as “human rights defenders”.
- RCs and UNCTs also need to galvanize stakeholders to act upon SDG 10 and 16 which includes specific indicators on the removal of discriminatory laws and practices.

Support and tools available from the United Nations system

- [Agenda for Zero Discrimination in Health Care](#) (2017);
- [Eliminating discrimination in health care. Stepping stone for ending AIDS](#) (2017);
- E-repository of tools to assess and address HIV-related stigma and discrimination in health care – zeroHIVdiscrimination.com;
- [Global Strategy on Human Resources for Health: Workforce 2030](#);
- [Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations](#);
- [Ethics guidance for the implementation of the End TB strategy](#).

**This two-pager was developed by WHO and UNAIDS based on the “Frontier Dialogues” on emerging human rights issues launched in 2016 by the former UNDG Human Rights Working Group with members taking the lead on specific issues. These messages were approved by the UNDG and have been incorporated into the UNDG Guidance Note on Human Rights for Resident Coordinators and UN Country Teams.*