

## Contributi

# Human rights as the basis for defining, measuring and promoting health

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### ABSTRACT

This paper describes methodology to measure health from a human rights perspective. We define 'unjust health gaps' as departures from normal functioning caused by violations of human rights. Normal functioning has previously been defined as functioning which is statistically typical in an age group of a sex of a species (a reference group). We add the condition that those composing a reference group for normal functioning must live under the environmental conditions that are critical to achieve normal functioning for the function in question. Using work by the WHO Multicentre Growth Reference Study, we illustrate the method for defining normal child physical growth. The *Convention on the Rights of the Child* states the right of children to grow up in a family environment, in an atmosphere of happiness, love and understanding, with access to health care services, and with caregivers who are informed about issues like the advantages of breastfeeding and good hygiene and environmental sanitation. WHO established an international reference group composed of breastfed children with non-smoking mothers and access to health care, to provide growth data to define normal and abnormal growth (stunting). This is a departure from the typical practice of choosing as a reference group those in a society living under the best socio-economic conditions. The rationale for this departure is that even those best off in a society may not live under the essential conditions for normal functioning. We show how this methodology can be used in health promotion settings such as schools and workplaces.

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## I diritti umani come base per definire, misurare e promuovere la salute (*traduzione*)

### Introduzione

Alcuni pensano che non sia saggio discutere la ricerca in promozione della salute nel quadro dei diritti umani, in quanto la loro arena è controversa ed altamente “volatile”. Altri invece lamentano gli scarsi risultati in sanità pubblica siano dovuti alla non sufficiente attenzione ai diritti umani. Noi non possiamo ignorare il rapporto tra salute e diritti umani, tanto per la salvaguardia di una migliore salute che della difesa dei diritti umani. L’attenzione sulla salute potrebbe essere infatti essenziale per il successo dei movimenti per i diritti umani [...]. Gli operatori ed i ricercatori sanitari possono trovare quello spazio che è negato a molti degli attivisti per i diritti umani [...]. Evidenziare i rapporti tra salute e diritti umani nel campo della ricerca in promozione della salute potrebbe essere un nostro obbligo etico [...].

Questo lavoro, partendo da un discorso generale su salute e diritti umani, tende a dare una risposta ad una questione di prospettiva ma anche pratica: *se la promozione della salute riguarda anche i diritti umani, come possiamo misurare la salute nelle ricerche nella promozione di essa dalla prospettiva dei diritti umani?* [...]. I risultati della ricerca *Closing the gap in a generation* indicano tre punti di azione: migliorare le condizioni di vita di ogni giorno, assicurare una corretta distribuzione del potere, denaro e risorse, misurare i problemi, valutare le azioni e allargare le conoscenze di base. Questo lavoro vuole rispondere proprio al richiamo a ricerche importanti, specialmente nella necessità di misurare la salute in modo rilevante rispetto alla giustizia sociale ed ai diritti umani. E dobbiamo anzitutto affrontare il fatto che la promozione della salute ha una relazione incerta con il compito di definire o soltanto misurare la salute [...].

Mentre i concetti generali di salute sono adeguati alla vita di tutti i giorni, occorrono definizioni operative ai fini della misurazione [...].

Ecco perché è importante la chiarezza nel contesto nel quale iscriviamo la misura della salute: in termini generali salute e diritti umani, più precisamente il convincimento che le disuguaglianze in salute sono violazione dei diritti umani [...].

Le disuguaglianze in salute sono il risultato di un funzionamento “normale” causato dalla violazione dei diritti umani [...].

Il concetto di salute normale è definito in rapporto ad un’età, al sesso ed specie specifico al quale ciascuno appartiene [...]. Ma il problema critico è il seguente: Qual è il più appropriato gruppo di riferimento dal punto di vista dei diritti umani? Età, sesso e specie non sono caratteri abbastanza specifici. Un nuovo criterio deve essere aggiunto: il gruppo di riferimento (età, sesso, specie specifico) è quello di chi vive in un insieme di condizioni ambientali che sono *fondamentali per ottenere il normale funzionamento delle funzioni considerate*. Per la specie umana, la popolazione che vive in condizioni sotto-ottimali non può essere il gruppo di riferimento per definire la salute normale. Quando le condizioni ambientali basilari per il normale sviluppo sono assenti vuol dire che siamo in presenza della violazione dei diritti umani. E siccome alcune condizioni sono essenziali gli uomini hanno diritto ad esse.

### Il diritto alla salute

Quelle appena espresse non sono certo idee nuove. Già oltre sessant’anni orsono l’art. 25 della Dichiarazione universale dei diritti umani diceva: *Ogni individuo ha diritto ad uno standard di vita adeguato alla salute ed al benessere proprio e della sua famiglia*.

In questo senso standard di vita non riguarda soltanto le condizioni materiali; si riferisce a tutte le condizioni richieste per la salute ed il benessere, nei limiti del caso e dei geni. Insomma, “diritto alla salute” vuol dire diritto a condizioni essenziali per la salute ed il benessere.

Vediamo ora alcuni esempi pratici di come la salute può essere gestita operativamente usando un quadro di diritti umani, rispetto alla salute dei giovani nel sud globale.

### La crescita dei ragazzi

La figura 1a mostra (in qualche modo) una distribuzione normale ma il punto di partenza per leggere le informazioni è nell'angolo superiore sinistro, in quanto la partenza sono i diritti umani. La Convenzione sui diritti dell'infanzia del 1989 afferma il diritto dei bambini di crescere in un ambiente familiare, in un'atmosfera di felicità, amore e comprensione, con genitori od altri assistenti che siano informati di problemi come i vantaggi dell'allattamento al seno, l'igiene e il disinquinamento, i pericoli del fumo passivo e così via.

Guardando al centro alto della curva, i bambini che vivono in tali famiglie sono un ragionevole gruppo di riferimento per la (misura della, *nota del traduttore*) salute di un infante normale: coloro che si occupano di lui hanno abitudini sane e forniscono una buona assistenza. In molte delle misure della salute dobbiamo essere interessati a simili gruppi di riferimento, specificando bene il contesto della ricerca [...].

Un ipotetico gruppo di studio può essere collocato in molte parti del mondo con diffusa povertà, fame endemica, troppo breve periodo di allattamento al seno, ambiente malsano e scarse dotazioni igieniche, servizi sanitari scadenti, in generale povere forme di assistenza all'infanzia [...].

Quando la salute è definita con l'approccio ai diritti umani, i bambini possono essere definiti sani rispetto ad altezza per il sesso e l'età quando si collocano nel *range* di normalità presente in un gruppo di riferimento che gode delle condizioni di vita essenziali per la crescita dei giovani [...].

Questo approccio per lo studio dello sviluppo dell'infanzia è stato sviluppato dall'OMS ma è poco apprezzato al di fuori di un piccolo gruppo di esperti che operano in questo campo nel Sud Globale. Ricerche per sviluppare standard dell'accrescimento sono state condotte in speciali località del Brasile, Ghana, India, Norvegia, Oman e USA.

In questi Paesi hanno selezionato luoghi ottimali di studio con bassa mortalità infantile, alta proporzione di madri che allattavano al seno, Ospedali baby-friendly che offrivano sostegno all'allattamento al seno; Madri non fumatrici, senza carenze ambientali o di salute che potessero ritardare una crescita normale, con figli nati a termine [...].

In queste ricerche sulla salute dell'infanzia c'è un esempio completamente operativo di come il quadro dei diritti umani può essere usato per definire e misurare la salute. E' complicato, impegnativo, richiede tempo e ricerche di qualità veramente elevata [...].

Questo approccio basato sui diritti umani può essere fattibile per ogni altro parametro di salute che può essere misurato in modo affidabile e valido, comprendente la salute fisica, sociale, mentale nonché parametri di benessere. Può essere usato a livello individuale, familiare o di comunità. Diciamo "può" perché non siamo a conoscenza di altri esempi sviluppati completamente di questo approccio ai diritti umani per definire e misurare la salute. Possiamo immaginare come questo metodo possa essere applicato ad altri problemi di salute, oltre questo, e quindi mostriamo due altri esempi.

### Bullismo a scuola

Il bullismo a scuola è nell'agenda quasi in ogni luogo, eccetto dove le scuole non ci sono - ma dove ci sono scuole lì c'è bullismo e vittime e miseria e sofferenza dovute ad esso. Secondo quanto stabilito dalla Convenzione sui diritti del ragazzo le scuole hanno l'obbligo di assicurare che la gestione corrente connessa con la sicurezza del ragazzo sia assicurata in modo coerente con sicurezza e umana dignità. Il gruppo di riferimento, in tal caso è composto da scuole (non da singoli individui) che forniscono ben documentati sicurezza, nutrimento e ambiente favorevole, senza alcuna tolleranza per il bullismo e con l'applicazione di interventi preventivi dimostratisi efficaci e funzionanti nel modo previsto.

*(Il testo prosegue con l'elencazione di requisiti necessari, di cose da misurare e di standard di accettabilità, nota della red.).*

Questi due esempi, uno già applicato sulla crescita ed uno ipotizzato sulla sicurezza dei ragazzi mostrano la fattibilità nel definire, misurare e monitorare la salute nel quadro dei diritti umani [...].

### **Luoghi di lavoro**

I diritti umani non sono ancora stati codificati in dichiarazioni internazionali e convenzioni firmate dai rappresentanti politici delle nazioni. Raramente definizioni precise e vincolanti sui diritti umani possono essere trovate in statuti, leggi, regolamenti internazionali nazionali e locali [...].

Un esempio ci viene dalla Norvegia, nella legge sull'ambiente di lavoro in vigore mentre scriviamo si stabilisce che l'ambiente di lavoro deve soddisfare queste esigenze:

- il lavoro deve essere organizzato in modo da proteggere l'integrità e la dignità dei lavoratori per dare ad essi la possibilità di contatto e comunicazione fra di loro;
- i lavoratori non debbono essere esposti a violenza o altre condotte oppressive e per quanto possibile debbono essere protetti dalla violenza, minacce e stress dovuti al contatto con gli altri [...].

I luoghi di lavoro che soddisfano tutte queste esigenze possono dunque essere presi come gruppi di riferimento e in tal modo possono essere stabilite le misure di base per identificare i lavoratori svantaggiati anche

relativamente al benessere ed alla qualità della vita. Possono anche offrire la base per documentare le differenze fra i livelli richiesti per la protezione dei lavori e livelli sotto-ottimali [...].

### **Conclusioni**

Questo non vuole essere un banale appello ai ricercatori in promozione della salute di abbandonare i loro programmi e diventare discepoli dell'approccio diritti umani [...].

Tuttavia alcuni dei nostri sforzi debbono essere rivolti verso lo studio della salute come definita nella prospettiva dei diritti umani [...] e perché questo avvenga dobbiamo meglio educare noi stessi sul salute e diritti umani [...]. Dobbiamo evitare di continuare a parlare cercare una definizione di salute definitiva, ma piuttosto considerare solo quello specifico per quel gruppo specifico [...].

Quando affermiamo che la salute è un diritto umano, usiamo una scorciatoia per dire che la gente ha il diritto di vivere nelle condizioni che sono fondamentali affinché sia completamente soddisfatto il loro potenziale umano. Dunque dobbiamo preferire gruppi di riferimento dei quali siano rispettati i diritti rilevanti e non solo i gruppi nelle società che hanno il maggior vantaggio economico e materiale. E fare il paragone tra il gruppo di riferimento e quello allo studio [...].

### **Introduction**

Some think it is unwise to discuss health promotion research in the framework of human rights, because the human rights arena is controversial and highly volatile. As Gruskin (2006) points out, some even blame poor public health results on 'unnecessary attention to human rights'. Yet we cannot and should not try to escape the health and human rights connection, both for the sake of better health and for the sake of

protecting human rights. A focus on health may be critical to the success of the human rights movement. Farmer (2003) calls attention to the esteem in which public health and medicine are held, which provides openings into human rights work that may otherwise not exist. Health workers and health researchers may have space to act for human rights that is denied to many human rights activists. As Farmer (2003) writes, a '*...focus on health offers a critical new*

*dimension to human rights work and is a largely untapped vein of resources, passion, and good will.*' To avow the connection between health and human rights, also in the health promotion research arena, may therefore be our ethical obligation. There is, of course, complexity in the health and human rights connection. Working for health may sometimes seem to violate human rights, as when the rights of some are trampled to protect the health of others, as can happen when epidemics break out. Yet such instances do not cancel the overwhelmingly positive relationship between health and human rights. Aside from the reticence that some express about approaching health promotion from a human rights perspective, a great many scholars have engaged these topics in tandem (recent contributions include Bustreo and Doebbler, 2010; Mann and colleagues, 2011; Nolan, 2010; Taket, 2012). The pages of this Journal have been particularly rich on this subject, with over 280 papers of various kinds published over the years. In this rich context, the present paper does not aim to contribute to the general discussion about health and human rights; the position that they are inextricably intertwined is taken for granted. Rather, this paper aims to move from the general health and human rights discourse to suggest one answer to a straightforward and highly practical question: *if health promotion is about human rights, how can we measure health in health promotion research, from a human rights perspective?*

This is a question that has currency for two reasons. First, human rights are high on the agenda of health promotion practitioners and researchers out in the field, evidenced by recent research showing that fully three-quarters of the membership of the *International Union for Health Promotion and Edu-*

*cation* that participated in a survey view human rights declarations as being an essential foundation for a code of ethics for health promotion (Bull, Riggs and Ncho-gu, 2012).

Second, human rights are also on the agenda of those in the forefront of health advocacy, amongst others the prestigious *WHO Commission of the Social Determinants of Health*. Its 2008 report *Closing the Gap in A Generation* (CSDH, 2008) makes an evidence-based, scientific, yet passionate plea that we take effective action to close the health gap by 2040:

*'(The health gap)...does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are... unfair...putting right these inequities... is a matter of social justice... social injustice is killing people on a grand scale.'*

The report has as its pinnacle three calls for action: we must improve the conditions of daily life, we must insure a fair distribution of power, money and resources, and we must measure the problem, evaluate actions and expand the knowledge base. It is this last action area, a call for relevant research, to which this paper responds, and especially the need for the *measurement* of health in ways relevant to social justice and human rights.

We first have to confront the fact that health promotion has a troubled relationship with the task of defining, yet alone measuring health. Our text books on health promotion focus mainly on techniques for *promotion* and the little space they give to the meaning of *health* is confusing. Some scholars emphasise that the meanings of health differ greatly across various health care disciplines (Koelen and van den Ban, 2004),

therefore any search for a single definition is simply misguided. Yet others see danger, such as Lupton (2003), who has written '*the official definitions and interpretations of health attempt to impose a version of health that is to the advantage of the state.*' In the same vein a decade earlier, Antonovsky (1979) wrote:

*'The WHO definition does not speak of physical (and perhaps even emotional) well-being as being shaped by or as interacting with social wellbeing. It declares flatly that everything people feel about their state of well-being is part of health and hence within the province of the health institution. From here, it is but a minuscule jump to saying that all aspects of a person's well-being are appropriately under the control of those who control the institution.'* (ibid, p. 52-53).

A more practical tone, with which our thinking is aligned, is sounded by Huber, et al (2011), who point out that while general conceptions of health are adequate in daily life, operational definitions are needed for measurement purposes. As measurement in research is specific to tightly-formulated research questions, many operational definitions of health are needed to satisfy many research contexts. So, if health can only be defined in context-specific ways, what is vital is *defining the context*; the definition of health will more easily follow.

That is why it is important to be clear about the context in which we write about the measurement of health: the context is health and human rights generally, and more specifically, the contention that unjust health gaps are violations of human rights. By the term 'unjust health gap' we mean any departure from normal functioning that is caused by violations of human rights. Others use the term 'health gap' much more broadly. For example, health differences between

different social strata are termed 'social gaps in health', which may or may not follow from injustice. But the present interest is in defining health in the confined context of human rights, so the concept of 'health gap' is narrowed to the term 'unjust health gap'.

An unjust health gap is a departure from normal functioning that is caused by violations of human rights. Breaking that down into its two parts, we give to the term 'normal functioning'

precisely the same meaning as does Boorse in his infamous Biostatistical Theory (Boorse, 2010). He writes that normal functioning is that which is statistically typical in an age group of a sex of a species. For any health measure – for example how many push ups you can do – whether you have 'normal functioning' or not depends on how you perform compared to the appropriate reference age and sex reference group. Health, according to the Biostatistical Theory, is 'statistically typical' functioning – what does Boorse mean by that? He used the normal curve to explain, showing that at some cut-point to the left of the curve, one stops being normal and becomes pathological. Similarly, at some point to the right of the normal curve one stops being normal, and is perhaps best described as having 'positive health'. He is not explicit about the cut-points for normality or how they may be set.

In life, we deal with the idea of health as normal functioning all the time. After taking your blood pressure, your physician may say 'within normal limits'. Alternatively she might say 'it is borderline high, let's check it again in a month'. Or, 'your blood pressure is quite high and we need to start treatment now to get this under control'. Cut-points for defining what is nor-



mal and what is abnormal take into consideration developing measurement technology, advancing medical knowledge, political decisions about what we should treat and what we should not, one's age and gender, the patient's general condition and medical history, and so forth. The point is, the range of functioning defined as normal is somewhat arbitrary. Normality is a social construction, to suit our human purposes, and alter at will, also to suit our purposes. Boorse has nothing to say about the appropriate reference group for defining normal health, except to say that it is defined with respect to the meaningful age-, sex- and species-specific group to which one belongs (Boorse, 2010). It is at this point that a definition of health in the context of human rights must take a departure from Boorse. The critical issue is this: what is the right reference group from a human rights perspective? Age, sex and species are not a specific-enough delineation. To these we must add a new criterion: The reference group is an age-, sex- and species-specific group living under the set of environmental conditions that are *critical to achieve normal functioning for the function in question*. For the human species, when critical environmental conditions for normal growth are absent, the people living under those sub-optimal conditions cannot be the reference group for normal health. When the critical environmental conditions for normal growth are absent, there is a violation of human rights. It is because the certain conditions are critical that humans have a right to those conditions.

### The right to health

These are certainly not new ideas. Sixty-three years ago, Article 25 of the Universal Declaration of Human Rights (UN Gene-

ral Assembly, 1948), expressed the idea this way: *'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family...'*.

Standard of living in this sense does not refer merely to material conditions; it refers to all the conditions of living needed for health and well-being, within the bounds of chance and genes. So, the 'right to health' refers to the right to the conditions essential for health and well-being. We now turn to a practical example of how health can be operationalized using a human rights framework, having to do with child health in the Global South.

### Child growth

Figure 1a shows a (somewhat) normal distribution, but the starting point for examining the information in Figure 1a is in the upper left corner, because the starting point is human rights. The *Convention on the Rights of the Child* (UN General Assembly, 1989) states the right of children to grow up in a family environment, in an atmosphere of happiness, love and understanding, with parents or other caregivers who are informed about issues like the advantages of breastfeeding, hygiene and environmental sanitation, the dangers of second hand smoke, and so forth. Moving to the top centre, infants in such families are a reasonable reference group for normal infant health; their caregivers have healthy habits and provide good childcare. In such a reference group we may be interested in many health measures, and it is important to be specific about the research context. In this case the measure is height-for-age, which is an excellent marker for child health generally. The infants who compose this reference group will vary in height at every age and also by gender. On the right of the curve, after

taking age and gender into account, some infants will be extremely tall, perhaps due to hormonal disturbances, genes or other factors. On the left of the curve, some infants will be extremely short, due perhaps to hormonal disturbances, genetic factors, chronic illness and/or under-nutrition. Infants in the middle range are defined as normal, even if there is a large range of variation. With regard to the measure of interest, height-for-age, these children are healthy. The cut-points for being larger than normal and smaller than normal are set in an arbitrary but thoughtful way. In the case of child growth it is common to define abnormal shortness (stunting) in terms of distance from the median of the normalised distribution of the reference group, at -2, -2.5, or even -3 Standard Deviations from the median. These or other cut-points will be chosen based on the specific research problem that is being addressed.

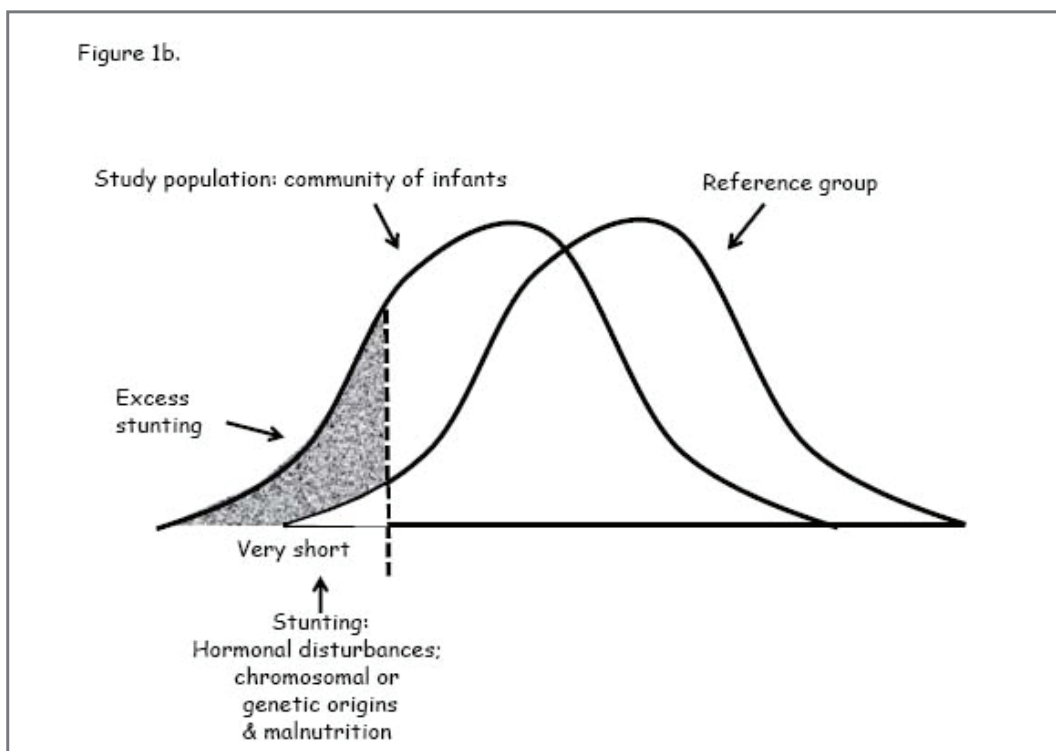
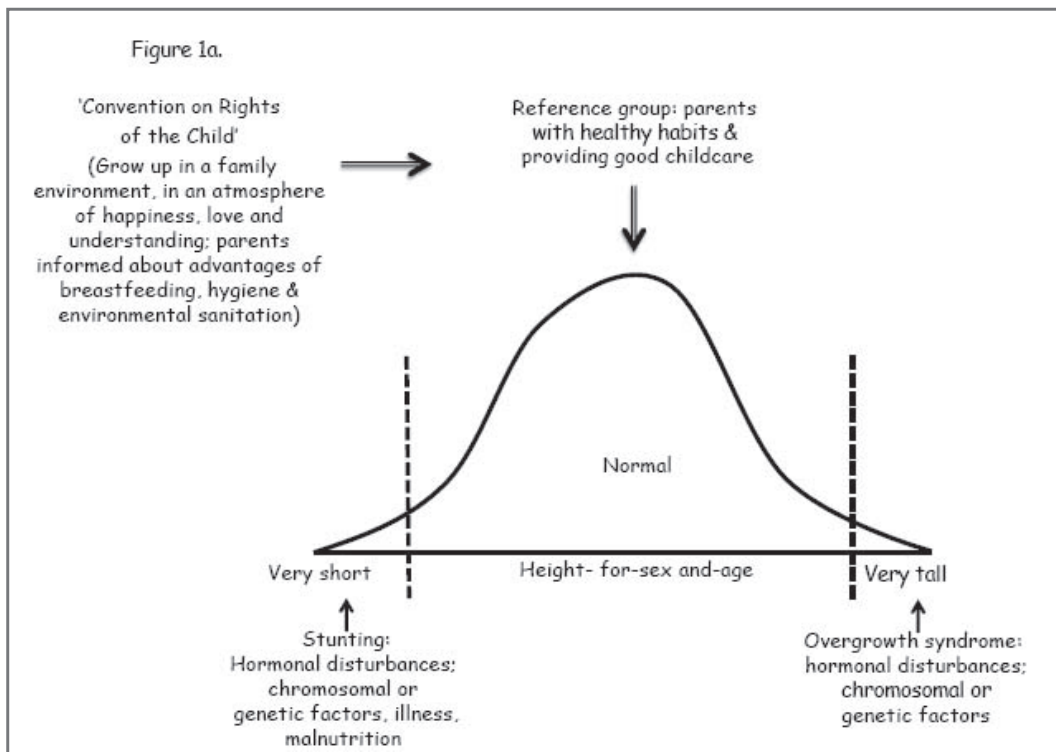
Returning to Figure 1a, this methodology produces an expected rate of abnormality when conditions are optimal. In the case of child growth, about 2.5 percent of children in the reference group are classified as stunted, when a cut-point of two Standard Deviations from the median is used. This 2.5 percent may be thought of as the expected base rate of stunting, among children living under the conditions that are essential for normal growth. Figure 1b has two curves, with the curve to the right being that of the reference group, and the curve to the left being that of some hypothetical study group, with a great many more stunted children than in the reference group. This hypothetical study group could be located in many parts of the world with widespread poverty, endemic hunger, too-short breastfeeding periods, unsafe environments and unsanitary conditions, poor health care, motherless

infants due to high maternal mortality, and poor infant care practices generally. Interventions in the study group area to provide all children with sufficiently nurturing environments would, hopefully, narrow or even eliminate the gap between the rate of stunting in the reference group and the study group. A stimulus to take remedial action is the knowledge that the excess rate of stunting in the study group is great, as shown by the shaded area in Figure 1b. Continuing surveillance would document an eventual narrowing, widening, or unchanging excess rate of stunting in the study group compared to the reference group.

That is how health is defined using a human rights approach: infants are defined as healthy with regard to their height for their sex and age, if they are within the normal range as defined in a reference group which enjoys the critical living conditions for infant growth. Even when the conditions are right, some children will be extremely short and others extremely tall. The cut-off for what is normal and what is not is derived from a knowledge-based consensus amongst experts, and the definition of normality will change over time as new knowledge becomes available. The cut-points have no important meaning for the individuals involved, but they do have relevance for policy-makers, public health professionals and health promoters. While cut-points are arbitrary as already pointed out, general agreement about such cut-points permits comparisons of studies from place to place and from time to time, and allows researchers to track trends in health.

This prescriptive approach to the study of infant growth has been developed by WHO, but it is little appreciated outside a small circle of experts working in the child growth arena in the Global South (de Onis, et al.,





2004). The research to develop the growth standards took place in selected locations in Brazil, Ghana, India, Norway, Oman, and the USA. In these countries, de Onis and her international team selected study sites with low infant mortality, with a high proportion of mothers with good breastfeeding practices, and having facilities such as Baby-Friendly Hospitals that provided support for breastfeeding. Within these supportive localities, the researchers selected mothers who were non-smokers and had no health or environmental or economic constraints that would hamper normal child growth, who were willing to breastfeed, and who had babies that were born within normal term. There were other selection criteria, but these were the main criteria used to define a reference group within which to chart normal infant growth. As would be expected in scientific work on child growth, key concepts and terms include anthropometry, child nutrition, childhood growth, growth curves, growth references, infant feeding practices and infant growth... and perhaps less expectedly, also human rights. Furthermore, WHO could not have been more explicit that the road travelled was a human rights road. In their Preface to the WHO scientific publication in which this work is presented in detail, WHO Director General Jong-wook Lee and United Nations University Rector Hans van Ginkel wrote, as their very first words,

*'Among the indisputable rights of children is the right to health. Without respecting this right and providing the necessary resources to secure it, we cannot hope to achieve any of the major development goals the world has united around in the United Nations Millennium Declaration.'* (Lee and van Ginkel, 2004).

So, what we have in the case of WHO's

research in infant health is a fully worked example of how a human rights framework can be used to define and measure health. It is complicated, it is time consuming, it requires painstaking research of very high quality. But it can be done. Some might be sceptical that this is a call for anything new in health promotion research, and point to lots of recent studies on the social gradient in health, showing that health inequalities are associated with inequalities in living conditions. But there is something new in the human rights approach, and it has to do with the definition of the reference group. The common approach is to divide a study sample into social strata based on level of income, or education, or occupation, select the most advantaged stratum as the reference group, and compare that group's health with the health in less advantaged strata. The logic of this approach is stated succinctly by Braveman and Gruskin (2003): 'We believe that the highest attainable standard of health can be understood to be reflected by the standard of health enjoyed by the most socially advantaged group within a society.' But they go on to write, 'One could argue that, given sufficient resources, the highest attainable standard could be far greater than that currently experienced by even the best off group in a society.' Indeed, that is precisely the consideration that led to the development of the prescriptive WHO child growth measurement approach, with age and sex reference groups selected based on access to critical conditions for healthy growth, rather than relative social and material standing within a society. Focusing on relative standing within a society with the best-off group as the reference might lead to an ill-founded satisfaction with the status quo if the best-off group does not have access to critical conditions for

development of health. A reduction of inequities in health within a society by this approach could still leave a significant and unjust gap compared to groups outside that society, or more precisely – to health potential given critical conditions for health. To quote the Ottawa Charter: *'Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.'* (WHO, 1986). The human rights-based approach outlined here should be feasible for any health parameter that can be measured reliably and validly, including physical health, social health, mental health and well-being parameters. The approach should be usable at the levels of individuals, families and communities. We write 'should' because we are unaware of other fully worked examples of this human rights approach to defining and measuring health. Yet we can imagine how this method could be applied to health issues other than child growth and we sketch two examples below.

### **Bullying in schools**

Bullying in schools is on the agenda just about everywhere, except places where children have no schools to go to – but where there are schools, there are bullies, and there are victims, and there is misery and suffering due to bullying. The Convention on the Rights of the Child (UN General Assembly, 1989) states that every child has the right to be safe from bullying, violence and the fear of violence from their peers. Therefore, schools have the obligation to ensure that school routines connected to child safety are administered in a manner consistent with the child's safety and human dignity. The reference group in this regard is composed of schools (not individuals) that

provide a documentable safe, nurturing, and socially-supportive environment, with no tolerance for bullying and tested-effective bullying prevention interventions in place and functioning as designed. The minimum standard might be that a school must meet the criteria for membership in a Health Promoting Schools network. Even in the most successful health promoting school, the social climate for the students will vary; many will experience school as wonderfully supporting and safe, but some will be bullied despite the best efforts of the school. The health measure is the rate of bullying at the school level, with bullying defined by an agreed standard (see for example the universally -accepted definition of Olweus [1993, p. 8-9]). The aggregate rate of bullying in reference schools establishes the base rate of bullying that society may not find acceptable, but must nevertheless tolerate, at least until more effect interventions are deployed. As the science and art of bullying prevention advances, new research will establish new, hopefully ever-lower base rates of bullying, and new standards will supplant older standards.

Compared to the reference group, study populations of schools may have higher rates of bullying (or not), and if study populations of schools with higher than base rates of bullying have not acted sufficiently to assure a safe social climate, bullying in those schools is a health problem that is due to a violation of children's rights. The degree of the violation can be quantified and tracked overtime, to determine if bullying trends are improving, remaining stable or worsening. Such surveillance would assist schools to set and monitor targets for improvement and stimulate intervention to reach targets. If, for example, the base rate of bullying in reference schools is 2 percent,

and research reveals a rate of 20 percent in study schools, the excess rate of bullying is 10 times the base rate.

These two examples, a worked example on child growth and a conjectural example on child security, illustrate the feasibility of defining, measuring, and monitoring health using a human rights framework. Within this framework, health is defined as the normal state of any given health measure in a reference group for whom the critical conditions for that measure are satisfied. The critical conditions will vary from health measure to health measure and from context to context. Health must therefore always be defined in context, and specifically, with reference to people having access to the critical conditions for the health measure in focus.

### **Workplace**

Human rights are not just codified in international declarations and conventions signed by nations' political representatives. Far more binding and precise statements of human rights are found in international, national, regional and local statutes, laws, court rulings and regulations. When these are sound from a human rights perspective, they may provide firmer bedrock for defining health than vaguer international human rights declarations. An example from Norway is the national Law on work environment in force at the time of this writing. Paragraph 4, Section 2 of the Law states that the work environment must meet these requirements:

- Work shall be organised in ways that protects the worker's integrity and dignity.
- Work shall be shaped to give workers the possibility for contact and communication with other workers
- Workers shall not be exposed to harass-

ment or other excessive conduct

- Workers shall, as far as possible, be protected from violence, threats and invidious stress due to contact with other people.

It should not take great imagination to envision how these codified rights could be the foundation for research on workplace health promotion. Research on worker well-being and quality of life, for example, might initially examine worker experience with regard to these four requirements, perhaps in an entire employment sector or industry. Workplaces scoring very well on meeting all these requirements could then be constituted as a reference group, and base rates of poor worker functioning (with regard to well-being and quality of life) be established through research in the reference group workplaces. This would also provide the basis to document gaps in the industry, between required levels of worker protections and sub-optimal levels of protection. Excess rates of poor functioning could then be calculated, with the results of this surveillance used to stimulate improvements in industry-wide work environments.

### **Summary**

This paper is not a naïve call for health promotion researchers to abandon their present programmes of research and becomes disciples of a human rights approach. Health promotion research must address a wide range of health endpoints, including positive health, but including also disease and disability endpoints, using the established research frameworks and methods, and with health operationalized in the ways that are currently common and accepted. But some of our effort should be shifted to the study of health as defined from the human rights perspective, wherein health is defined as the

normal condition of people having access to the critical conditions for health. For this to happen, we, the health promotion research community, will have to better educate ourselves about health and human rights. Our conferences should increase emphasis on health and human rights and our journals should devote more space to the subject. In the context of our research, we should cease endless debate about the meanings of health and agree that health is only definable for specific measures and in specific contexts, and that this is perfectly ok. We do not mean the contexts of people's daily lives; we mean the contexts of the research problems we tackle. Within the framework of specific health measures and research contexts, we should define health as

the normal state in a reference group living under the critical conditions for health. When we say that health is a human right, we are using shorthand to say that people have the right to live under the conditions that are critical if their human potential is to be fulfilled. Therefore, we should prefer reference groups whose relevant rights are respected, and not just the groups in a society who have the most economic and material advantage. We should make the appropriate measurements in the reference group, and also in study groups, and make comparisons. Finally, we should engage in health promotion, including advocacy, with the goal that all people should enjoy the critical conditions required to enjoy health.

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