Advancing the **right to health** through the

UNIVERSAL PERIODIC REVIEW

A review of health under the first and second cycles of the Universal Periodic Review

HUMAN RIGHTS CENTRE CLINIC

World Health Organization

Advancing the right to health through the universal periodic review

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ACKNOWLEDGEMENTS

"Based on a detailed review of the first and second cycles of the UPR, this report reflects on what could be done differently to improve the impact of the UPR in advancing the right to health, and where stakeholders such as the World Health Organization can positively contribute"

The Universal Periodic Review (UPR) is a comprehensive, State-to-State peer review mechanism of the UN Human Rights Council which was introduced in 2006 to scrutinize the human rights record of every UN Member State (1).[1] Designed to redress the perceived country bias and selectivity of the UN Commission on Human Rights (2), its predecessor, the recommendations that have emerged from the UPR have been criticized for being overly focused on civil and political rights to the detriment of economic, social and cultural rights (3). This perception may have contributed to the relative under-use of this process in global health governance. However, following the adoption of the 2030 Sustainable Development Agenda, the UPR has started to attract increasing attention. NGOs, think tanks, UN agencies and 'interested' Member States consider that it creates opportunities for a wide, multi-sectoral dialogue at both national and global level, and that, under the 2030 Agenda, it can strengthen accountability, including for economic, social and cultural rights (4, 5).

These shifts suggest that the UPR has an unfulfilled potential: to strengthen national processes of monitoring and accountability, increase international scrutiny of a range of issues, and focus attention on realization of the right to health.

In 2015, WHO began a two-year project with the Human Rights Centre Clinic at the University of Essex to study how health has been addressed by the UPR. The project reviewed references to health in UPR recommendations to identify trends and patterns – how frequently health was mentioned, which health issues were mentioned most frequently, whether the issues mentioned were the most pressing, and what can be inferred from the ways in which States received and made recommendations. The aim was to determine whether the UPR offers opportunities to which international organizations such as WHO should give more attention. Could the UPR advance global health and human rights accountability? If so, how might WHO and other actors make fullest use of it?

The report reviews the extent to which health was addressed during the first and second cycles of the UPR. It asks what could be done to increase the UPR's influence on the right to health, and what role UN Specialized Agencies such as WHO might play. It is written primarily for health and human rights advocates, activists and policy makers.

The report exposes some surprising trends that challenge current perceptions that the UPR has neglected economic, social and cultural rights, and more specifically health issues.

Indeed, even a relatively narrow reading of 'health', that excludes some of its underlying determinants, showed that nearly a quarter of all recommendations (in the first cycle) were health-related – a trend that continued in the second cycle.

The health-related recommendations showed widespread concern for gender-based violence[2] and harmful practices. These comprised over one third (33%), while issues relating to maternal, child and adolescent health composed nearly a quarter (21%). On the other hand, mental health and HIV were not frequently raised, suggesting that health issues have not been scrutinized equally.

The same pattern was mirrored across all regions throughout the first cycle. Three topics of health, were the subject of two-thirds of all recommendations associated with health. Some region-specific patterns also emerged. Nutrition figured highly among recommendations to South East Asian countries, and non-communicable diseases in the Western Pacific.

Similarly, certain issues were consistently under-reported in recommendations across almost all other regions. Notwithstanding the regional trends above, under-reported issues included nutrition, water and sanitation,

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1 Figures in round brackets signal references. These are listed at the end of the report.
2 This heading also groups recommendations that referred to 'violence against women', 'sexual violence' and 'intimate partner violence'.

Health-related recommendations in the first and second cycles of the Universal Periodic review

Health issue	First cycle (%)	First cycle (n)	Second cycle (%)	Second cycle (n)
Gender-based violence and harmful practices	33.17	1788	29.93	3086
Maternal, children and adolescent health	20.93	1128	18.53	1910
Social and economic determinants of health	12.78	689	19.64	2025
Health systems and services	9.20	496	8.54	880
Women's health	7.32	395	6.96	718
Disabilities and health	7.27	392	6.16	635
HIV/AIDS and STIs	2.48	134	1.63	168
Sexual and reproductive health and rights	2.08	112	2.81	290
Health of LGBTI persons	1.22	66	1.06	109
Water and sanitation	0.95	51	1.72	177
Mental health	0.72	39	0.75	77
Nutrition	0.52	28	0.50	54
TB, malaria and neglected tropical diseases	0.33	18	0.18	19
Non-communicable diseases	0.32	17	0.31	32
Communicable diseases	0.26	14	0.29	30
Essential medicines and health products	0.22	12	0.23	24
Immunization, vaccines and biological medicines	0.13	7	0.10	10
Health security, emergencies and disaster relief	0.07	4	0.64	66

Legend:
- Share (%) of all issues raised globally: first cycle
- Share (%) of all issues raised globally: second cycle
- Number of health recommendations per health issue: first cycle
- Number of health recommendations per health issue: second cycle

Figure 1. A comparison of health-related recommendations addressing each health category during the first and second UPR cycles

non-communicable and other communicable disease, access to essential medicines, and mental health.

The project assessed the extent to which the UPR raised relevant health issues by comparing UPR health recommendations with established national and international health priorities. These findings from the first cycle showed a strong correlation overall between UPR recommendations and WHO-supported technical assistance strategies,[3] UN Development frameworks, and the international development agenda, including regional Strategies.[4] In the Africa region (AFRO), for example, over 20% of UPR recommendations associated with health referred to maternal and child health, and nearly 10% to strengthening health systems, matching the regional commitment to reduce maternal and newborn mortality and morbidity and improve health services.

The project found that among a sub-sample of eight countries, 59% of the UPR recommendations made to those countries in the first cycle had been fully or partially implemented within two years. At the same time, many recommendations could not be implemented in practice because they requested 'action' in terms that were general or normative rather than operational.[5] There

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3 Also known as Country Cooperation Strategies.
4 Many of the issues addressed have been prioritized globally, including in the Sustainable Development Goals and their predecessors, the Millennium Development Goals.

Human Rights Council 19th Session Proceeds, UPR Reports Reviewed

may be various reasons for this that have been explored in more depth elsewhere: some State and stakeholder summaries lacked information, some reviewing States did not prioritize specificity, and on some contentious issues a deliberate effort was made to create space for dialogue inside the country (6).

While this paper can report that a relatively high number of UPR recommendations reference health-related issues, and that UPR has the potential to increase reporting of and technical support for health, the research also raised some important questions that should be considered as the UPR continues in its third cycle. Some of these questions concern the reporting cycle itself. The spread of health issues raised, and the dominance of certain issues, suggest that more comprehensive grassroots participation would produce a more balanced spread of recommendations. Other questions concern how recommendations are

formulated by States.

An enduring challenge, identified here and in other studies, is how to unpack and implement intersecting and indivisible rights in a way that makes them easy to implement and monitor, without creating ineffective and siloed responses.

During the UPR's third cycle, it will be a practical challenge to introduce new and emerging rights issues while continuing to manage and monitor the implementation of the recommendations from previous cycles. The fact that the number of recommendations has steeply increased with each cycle makes this challenge increasingly acute.[6]

This report could not address all the questions it raises. How they are answered is nevertheless likely to determine how much health is addressed, and improved, through the UPR.

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5 This analysis corresponds broadly to the findings of the Universal Rights Group, which measured the 'usefulness' and measurability of recommendations. Subas Gujadhar and Marc Limon, *Towards the Third Cycle of the UPR: Stick or Twist? Lessons learned from the first ten years of the Universal Periodic Review* (2016, Universal Rights Group, Geneva). It should be noted that different studies make use of varying methodologies for enumerating and categorizing recommendations. Therefore, figures derived from this research will not be identical to those found in other studies.

6 21,355 recommendations were issued during the first cycle and 36,331 during the second (2).

PART ONE

The Universal Periodic Review: Engaging on health

This report presents the findings of a two-year research project of WHO and the Human Rights Centre Clinic of the University of Essex, which reviewed recommendations from the first and second cycles of the Universal Periodic Review (UPR) to assess whether and to what extent these addressed health. The review established:

• The incidence of health-related UPR recommendations made to States.

• The health issues that were most frequently addressed or neglected, and the types of actions that were most commonly requested of States.

• How far States have implemented UPR health recommendations that they accepted.
• The degree to which UPR health recommendations tend to align with national and international health priorities.

The project aimed to identify how more intense stakeholder engagement could focus attention on the most pressing health issues, and what role WHO and other international organizations might play in supporting Member States to achieve this goal.

The UPR is a State-led, peer review mechanism of the UN Human Rights Council. It reviews the performance of every country in fulfilling a wide variety of rights, one of which is the right to enjoy the highest attainable standard of health and wellbeing.

The UPR was introduced in 2006, under UN General Assembly resolution 60/251 (7). It was designed to carry out a review with the goals described in the quotation below.:

> The fulfilment by each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States; the review shall be a cooperative mechanism, based on an interactive dialogue, with the full involvement of the country concerned and with consideration given to its capacity-building needs; such a mechanism shall complement and not duplicate the work of treaty bodies

A child and her caretaker at the hospital. Marka, Somalia

> The process aimed to improve promotion and protection of human rights on the ground.

While primarily an accountability tool, the UPR's public process of review and scrutiny, including by non-state actors, provides an opportunity for States to share best practices, and highlight capacity-building needs and challenges that States face when they implement their human rights obligations.

The UPR process is led by the Working Group of the UPR, which consists of the 47 Member States of the Human Rights Council.[7] However, any UN Member State can make recommendations during UPR working sessions, which take place tri-annually in Geneva. The country reviews themselves are based principally on three documents, which are submitted in advance of an interactive dialogue: a state report, a stakeholder summary document (based on information from national human rights institutions and non-governmental organizations), and a compilation of UN information. At the completion of each country's review, a 'troika' (three states that serve as 'rapporteur' of the review process) prepares an outcome report which summarizes the questions and comments to the State under Review, and lists recommendations. The State under Review is entitled to respond to recommendations by either 'noting' or 'accepting' them; and in subsequent reporting rounds is held accountable for its progress towards implementing the recommendations that it has accepted (8).

The first UPR Cycle ran from 2008 to 2012, during which 12 sessions each reviewed 16 countries. The second UPR Cycle drew to a close in 2016. Ten years into its existence, the UPR is one of the most widely endorsed human rights monitoring mechanisms. It enjoys almost unanimous support from UN Member States (9).

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7 States are elected to the UN Human Rights Council for five-year terms. Elections are held annually for one fifth of the seats on a regional group basis.

STATE IMPLEMENTATION

STATE REPORTING

International technical assistance and capacity building support for implementation
Consultation with UNCT (e.g. integration of accepted recommendations into UNDAFs), and with other development partners

Some States prepare and submit voluntary mid-term reports

Ongoing monitoring of implementation and impact
Impact: for example, using OHCHR human rights indicators
Monitoring: by governments (e.g. SNICRS), by NHRI, by local NGOs
Oversight: by parliament (e.g. human rights committee)

Domestic coordination for implementation
Effective implementation should involve all relevant line ministries and agencies, parliaments, judiciary, NHRI and domestic NGOs
Standing National Implementation Coordination and Reporting Structures (SNICRS)

National consultation process
*"National reports should be prepared through a broad consultation process at the national level with all relevant stakeholders" (IBP)

Domestic dissemination of UPR outcome (including recommendations)

Elaboration of national report
(including status of implementation of previous recommendations)

| By NHRI/NGOs | By Permanent Mission | By OHCHR |

NATIONAL LEVEL PROCESS

SUBMISSION OF UPR REPORTS

TRANSMISSION OF OUTCOME TO NATIONAL LEVEL

INTERNATIONAL LEVEL PROCESS

| UN compilation report | National report | NGO/NHRI compilation report |

Final adoption of the outcome report by Council plenary (item 6)

Consideration of three reports by reviewing States
UPR info pre-sessional meetings with NGOs

NGOs offer general comments on the outcome

48 hours

Presentation of national report by SUR delegation

Reviewing States express views on the outcome

SUR expresses views, and replies to questions and issues not sufficiently addressed in UPR Working Group

Thematic clustering of recommendations

Extension of State-to-State recommendations

Interactive dialogue between SUR and reviewing States

Reactions and views of A-status NHRIs

SUR offers final response to recommendations made

Adoption of UPR outcome report by the Working Group

Preparation of UPR outcome report by troika*
*with involvement of SUR and assistance from OHCHR

ADOPTION OF REVIEW OUTCOME BY THE HUMAN RIGHTS COUNCIL

PEER REVIEW IN THE UPR WORKING GROUP

Figure 2. The UPR process. Adapted from Universal Rights Group, *Towards the 3rd cycle of the UPR: Stick or Twist?* (2016)

The UPR began its third cycle in 2017, and a surge of recent analysis has sought to assess the impact and shortcomings of the process, and what lessons could be gleaned from the previous two cycles (10,11). The UPR has been criticized on several grounds. It was said to be skewed towards civil and political rather than economic, social and cultural rights, in part because Ministries of the Interior and Ministries of Justice, rather than Ministries of Health or other social ministries, dominated the represented States under Review (12).

Some studies suggest that there may be higher implementation of economic, social and cultural rights, with issues related to HIV and the right to health ranking among those issues showing the highest implementation levels at mid-term (13). In addition, although some NGOs have participated actively in the UPR to promote economic, social and cultural rights (notably children's rights and sexual and reproductive health rights), only a handful of UN organizations (principally UNHCR, UNESCO and UNFPA) have actively and

> **The Human Rights Council's Universal Periodic Review process is now entering a new cycle, with every Member State scheduled for a third round of scrutiny. We will work to strengthen the relevance, precision and impact of the Council's recommendations, including by providing better support to Member States in implementation, stronger collaboration with United Nations country teams and the establishment of national mechanisms for human rights reporting and follow-up to link the Universal Periodic Review to the implementation of the Sustainable Development Goals**
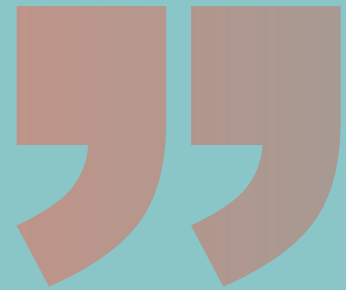
Report of the Secretary-General on the strengthening of the United Nations action in the field of human rights through the promotion of international cooperation and the importance of non-selectivity, impartiality and objectivity (15)

strategically engaged with the UPR. WHO, for example, has been little involved.

This changed somewhat after the 2030 Development Agenda and the Sustainable Development Goals (SDG) were adopted in 2015. There has been a renewed push to strengthen the support given to Member States by the UN system as a whole, by "providing country-specific technical assistance and capacity-building efforts" that focus on implementation and follow-up (14, 15). It is evident that, to do this effectively, the UN and its partners need also to engage more actively in order to identify the issues that require attention.

This report encourages a new narrative about the UPR and the opportunities it offers to improve reporting and accountability, and technical support in relation to health and health policies. Our research raises important questions for reporting states, multilateral agencies and NGOs as the UPR continues its third cycle. How might the reporting process be strengthened to ensure more balanced grassroots participation? How might more Ministries participate in implementing UPR recommendations that cross a range of policy areas? How can States best examine new rights issues while monitoring the implementation of UPR recommendations from previous cycles? This report does not address all these questions, but the answers to them will affect how much and how well in the future health is addressed, and improved, through the UPR.

PART TWO

Methodology: Framing health-related UPR recommendations

WHO's Constitution defines health as a human right, and as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. Under the International Covenant of Economic, Social and Cultural rights, the right to the highest attainable standard of health is understood to be indivisible from other human rights, including nutrition, housing, education, and water and sanitation.

The right to health is a broad human right encompassing a right to healthcare, as well as underlying determinants of health. It also gives rise to obligations on States to adopt appropriate legislative and policy frameworks. Since this research is aimed at, in the future, engaging WHO country offices and their counterparts at the Ministry of Health on health issues through UPR recommendations, the research team decided to only include recommendations which were explicitly framed as engaging the right to health and/or which relate to mandate and field of operations of WHO's work. The main implication of this is that a number of other recommendations fall beyond the scope of this review because they are primarily focused on other human rights but which are nevertheless important for the right to health.

To enable the research team to judge how fully 'health' has been addressed in recommendations of the UPR, they developed criteria and a methodology for classifying recommendations according to the health issues they addressed, and the types of action recommended, drawing on WHO health categories and the core priorities established (at the time of the first and second cycles of the UPR) in WHO's Twelfth Global Programme of Work.[8] This categorization would be used to measure the frequency of

health-related recommendations. The team then conducted a pilot analysis of a smaller subset of states to test the adequacy and appropriateness of the approach. To ensure consistency, after the analysis of all States was carried out, one team member was assigned as reviewer. The reviewer randomly selected 10 percent of the countries from each WHO region. In total, 20 countries were reviewed from across all regions.

These criteria were applied to measure the frequency of health-related recommendations; and the degree to which frequency of health recommendations matched health priorities established under WHO's mandate and programme of work. In addition, and in contrast to other studies of its kind, the research team separated out health issues and types of recommendation (defined as the actionable part of the recommendation).[9]

The issues included in the scope of the project are listed in Figure 3. The main consequence of the methodology chosen is that some UPR recommendations that are relevant to health fell outside the review's scope. Examples include freedom from torture and the right to adequate housing. Though both are clearly underlying determinants of the right to health, neither falls within the remit of this review.

It should be noted that most of the recommendations that raised health-related issues flagged more than one of the identified health categories and that, for the purposes of the project, all categories flagged were included separately in the review. It follows from this that the number of health categories reported per country and per region is larger than the number of recommendations that raised health-related issues.

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8 It is important to note that the review took account of recommendations that did not explicitly employ human rights language. To do otherwise would have unreasonably narrowed the scope of the exercise. **9** See Annex 1.

HEALTH CATEGORIES

The study identified the following health categories based on the WHO's Twelfth Global Programme of Work

1 Health systems and services

2 Health security, emergencies and disaster relief

3 Non-communicable diseases (NCDs)

4 Communicable diseases

5 Sexual and reproductive health and rights (SRHR)

6 Mental health

7 Social and economic determinants of health (SDH)

8 Gender-based violence and harmful practices (GBV)

9 Women's health

10 Maternal, child and adolescent health (MCA)

11 Essential medicines and health products

12 The health of persons with disabilities

13 The health of lesbian, gay, bisexual, transgender or intersex (LGBTI) persons

14 HIV/AIDS and Sexually Transmitted Infections (STIs)

15 Tuberculosis (TB), malaria and neglected diseases

16 Immunization, vaccines and biological medicines

17 Water and sanitation
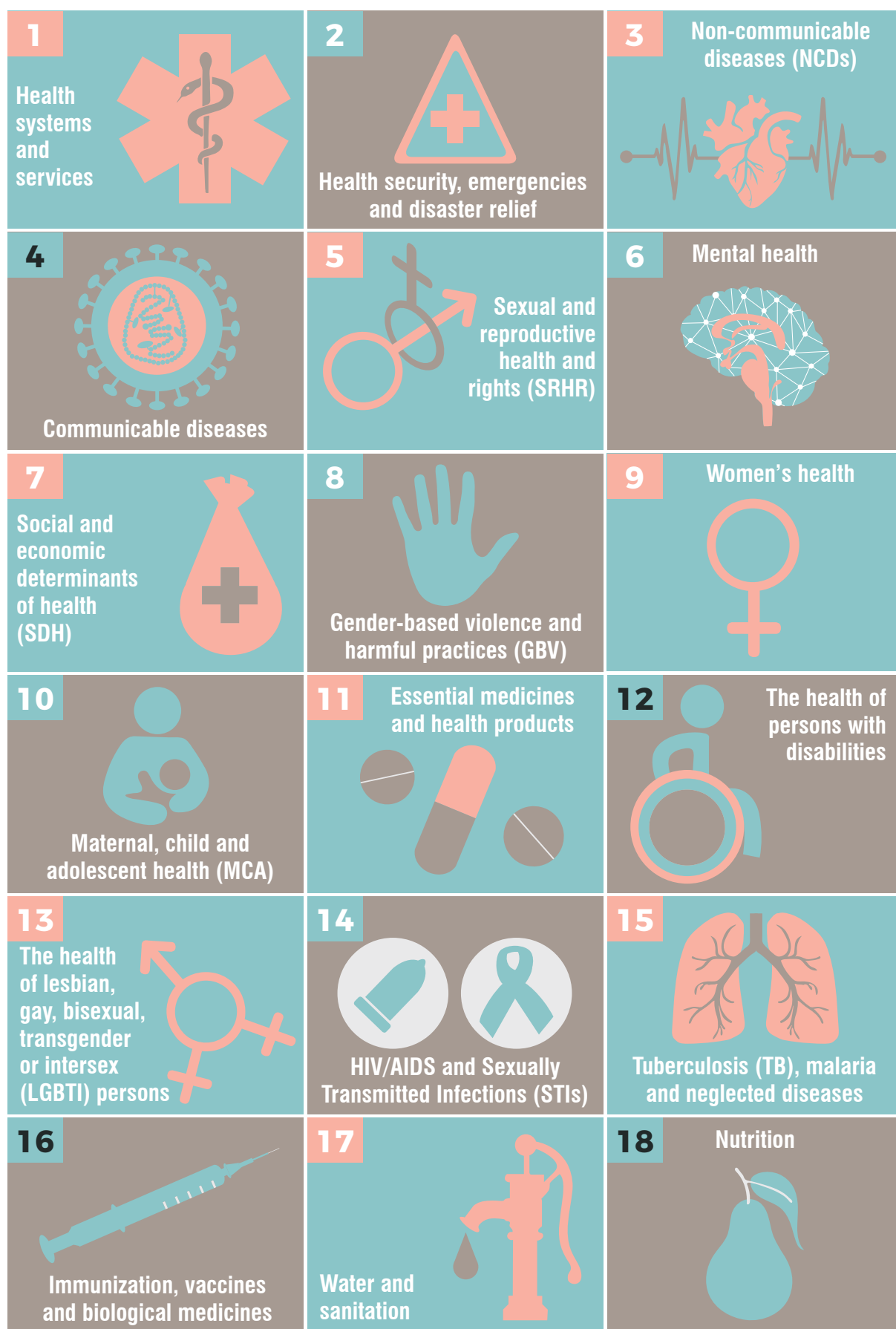
18 Nutrition

Figure 3. The project's health categories (based on WHO categories)

The project's six types of health-related recommendation

Type of Recommendations	Explanation
International human rights mechanisms	Covers recommendations that encourage states to: ratify international human rights treaties; invite UN Special Rapporteurs; implement recommendations from treaty bodies' Concluding Observations; implement Comments or other relevant documents.
Legislation	Covers recommendations that approve or call for: changes in legislation; changes to the legal framework; the repeal of certain legal provisions.
National funding	Covers recommendations to allocate or increase funds to: a certain issue that engages the right to health; the health sector or health services.
International cooperation (funding and technical assistance)	Covers recommendations that engage the international community, assistance, cooperation and funding, either by encouraging the State under Review to seek assistance from other states, or by requesting the State under Review to share its expertise in a particular region.
Policies and programmes	Covers recommendations concerned with the enforcement or implementation of human rights through policies, procedures, programmes, services or other facilities.
Other	Covers recommendations that refer to issues of health but do not fit any of the above categories.

The data was analysed to provide global averages. It was also disaggregated by region using WHO's geographic classification (16).

The second phase of the project examined in more detail the UPR recommendations to eight countries: Cambodia, Chile, Jamaica, Lebanon, Malawi, Moldova, Mozambique, and Nepal. Recommendations from both the first and second cycles [10] were analysed to identify the types of recommendation issued and the health subjects addressed.[11] The project also assessed the extent to which first cycle recommendations to these countries had been implemented. This information was derived from a database developed by UPR Info, an NGO that has comprehensively analysed UPR recommendations, including their implementation (17).

This second phase also compared the content of recommendations with the content of the background information on each State that is prepared before its review, and with the national priorities set out for each country in the UN country team's workplan and UN Development Assistance Frameworks (UNDAFs). UNDAFs reflect national priorities that the UN is committed to support: these may not reflect all key health and human rights issues in a country but provide a practical and coherent measure for assessing policy priorities.[12] This comparative analysis enabled us to judge the degree to which the country health categories prioritized by the UN coincided with UPR recommendations to the same States.

Subsequent to the completion of the second phase, the methodology for the first phase was replicated for all recommendations made to all countries during the second cycle. Preliminary findings relating to health-related recommendations made during the full second cycle are also provided in the sections that follow in this report.

Additional detail about study aims and methods may be found in Annex 2 of this report.

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10 The selection and small size of the sample was due simply to the project's limited budget. The selection of countries was diverse geographically, economically, and socioculturally.

11 Studies of the UPR have categorized types of recommendations in different ways. For example, E. McMahon adopted five categories: (1) recommendations for States not under Review (e.g. international cooperation); (2) continuity of actions; (3) to consider change; (4) action that is general; and (5) specific actions. (In *The Universal Periodic Review: A Work in Progress* (2006, Friedrich Ebert Stiftung), at: http://library.fes.de/pdf-files/bueros/genf/09297.pdf.) The Center for Economic and Social Rights adopted six categories: (1) take general action; (2) engage with international bodies; (3) accede to treaties; (4) enact laws, policies, programmes; (5) ensure implementation of enforcement; and (6) dedicate resources. (In The UPR: A Skewed Agenda? (2016), at: http://www.cesr.org/section.php?id=240.)

12 UNDAFs set out the priority areas of UN development assistance and are aligned with nationally-determined priorities.

PART THREE

Findings: Comprehensive review of UPR cycle 1 and selective review of cycle 2

1 RECOMMENDATIONS FROM THE FIRST CYCLE OF THE UPR

a. Even when narrowly defined, health-related recommendations represent nearly a quarter (22%) of all recommendations made to States during the first cycle of the UPR.

A total of 17,638 recommendations were made during the first cycle of the UPR. By the end of the cycle, the average was 144 recommendations per State (compared with 27 per state in the first session of the first cycle). 3,862 (22%) of these recommendations were 'health-related' (as defined by the project's criteria). A similar study by the Center for Economic and Social Rights investigated the proportion of UPR recommendations on economic, social and cultural rights; it concluded that these rights were addressed exclusively in 17% of recommendations, with a further 30% of recommendations focused on both ESC and civil and political rights. Health was found by the CESR to be the third most addressed ESC rights topic. These two different approaches led to differences in the way health issues were presented. For example, the WHO-Essex University project linked GBV to the right to health, while the CESR study viewed this issue within a broader remit of 'women's rights' and related to both civil and political as well as economic, social and cultural rights.

Relative to the number of human rights that could potentially feature in UPR recommendations (the Universal Declaration of Human Rights alone includes 25 different human rights standards), this figure suggests that, overall, the issue of health has not been neglected. However, the research did not calculate the frequency of references to other specific human rights (such as education, housing or detention) and therefore did not assess the comparative frequencies of references to health and references to other specific rights or human rights topics.

Gender-based violence was considered a health-related recommendation for the purpose of our review because for many years it has been understood to be "a global health problem of epidemic proportions" (18). However, gender-based violence is also a direct violation of several other human rights and freedoms, in addition to health. This contributes to its prominence as an issue of concern.

b. Distribution of health recommendations by WHO region.

The pattern of recommendations across the different WHO regions suggested that opportunities exist to engage more deeply with the UPR process (Figure 4). The percentage of health recommendations in each WHO region (relative to the total number of recommendations in each region) is listed below (first UPR cycle).

- WPRO 26%.[13]
- AFRO 25%.[14]
- AMRO 24%.[15]
- EURO 20%.[16]
- SEARO 19%.[17]
- EMRO 14%.[18]

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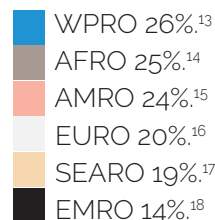
13 Western Pacific: 539 of 2080.
14 Africa: 1116 out of 4423.
15 The Americas: 722 out of 3024.
16 Europe: 910 out of 4487.
17 South-East Asia: 224 out of 1153.
18 Eastern Mediterranean: 351 out of 2471.

EURO 20%

AMRO 24%

AFRO 25%

SEARO 19%

EMRO 14%

WPRO 26%

1 WPRO region (25.92% - 539/2080)
2 AFRO region (25.23% - 1116/4423)
3 AMRO region (23.88% - 722/3024)
4 EURO region (20.28% - 910/4487)
5 SEARO region (19.43% - 224/1153)
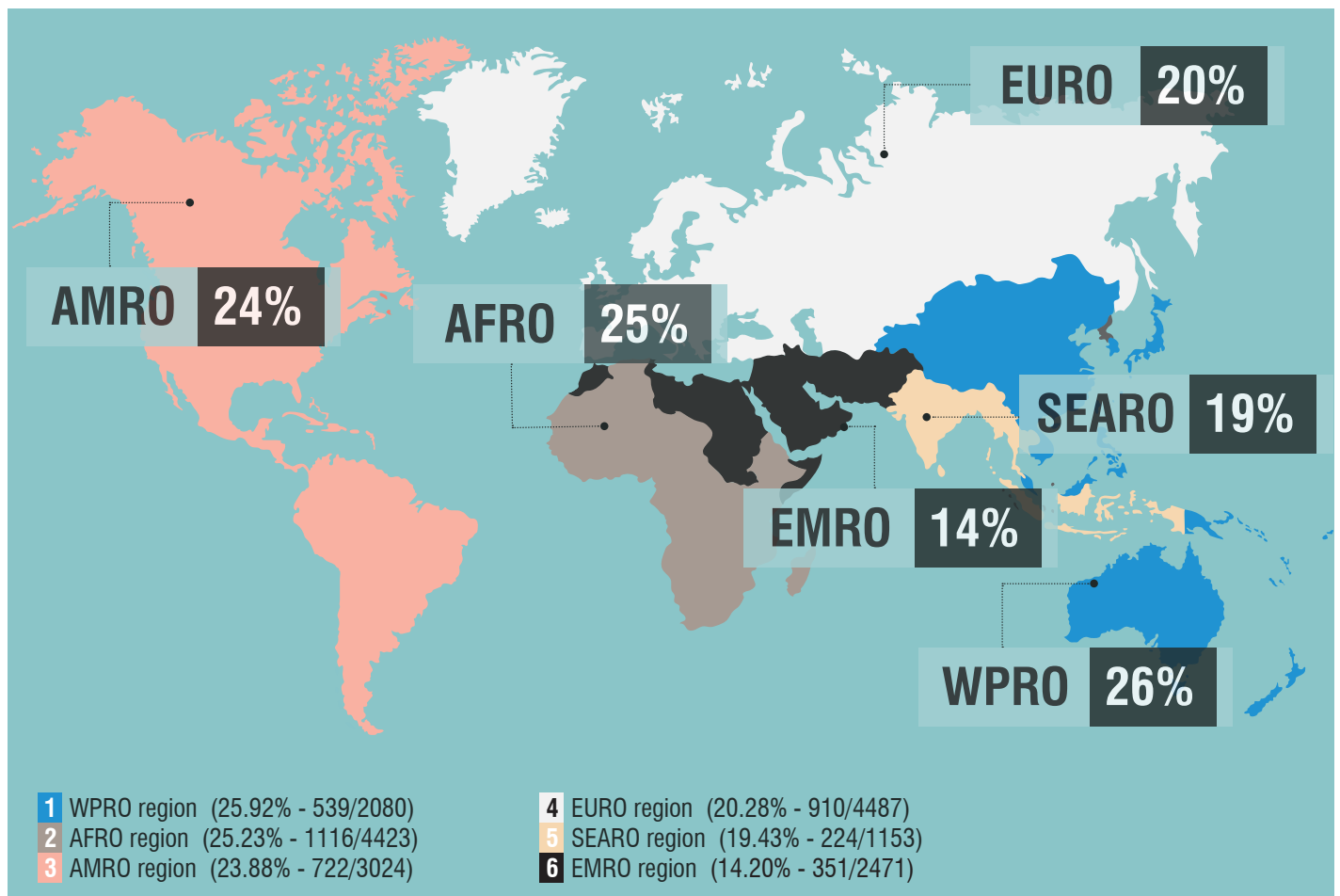6 EMRO region (14.20% - 351/2471)

Figure 4. The percentage of health recommendations received on health by countries in each WHO region

c. States that made and received recommendations on health.

Figure 5a lists those States that issued the highest number of health-related recommendations during the first cycle. All the States in question have ratified a high proportion of the international human rights treaties that recognize the right to health. Several have Constitutional protections that uphold the right to health (Algeria, Argentina, Canada, Slovenia, Spain, Mexico) (19). Two are among the most compliant States in terms of reporting on human rights (Canada, Spain), indicating a strong engagement with human rights mechanisms (20). However, it is notable that this ranking is dominated by States from just two of the six WHO regions, the Americas (AMRO) and Europe (EURO).

Figures 5b and 5c indicate which States received the highest and lowest proportions of health-related recommendations as a proportion of all recommendations received. In the first case

(5b), small and/or island states predominate to a striking degree (exception made for South Africa and Republic of Congo). This finding raises a number of questions, and further research would be required to understand it.

> **States that issued the largest number of health-related recommendations have ratified a high proportion of the international human rights treaties that recognize the right to health**

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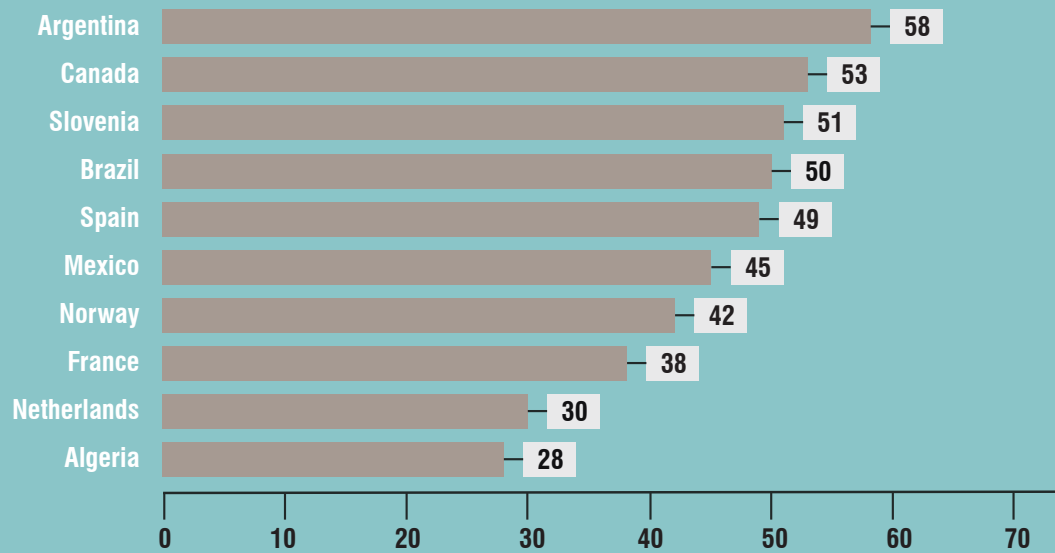
Figure 5a. The ten States that made the largest number of recommendations related to health

Country	Value
Argentina	58
Canada	53
Slovenia	51
Brazil	50
Spain	49
Mexico	45
Norway	42
France	38
Netherlands	30
Algeria	28
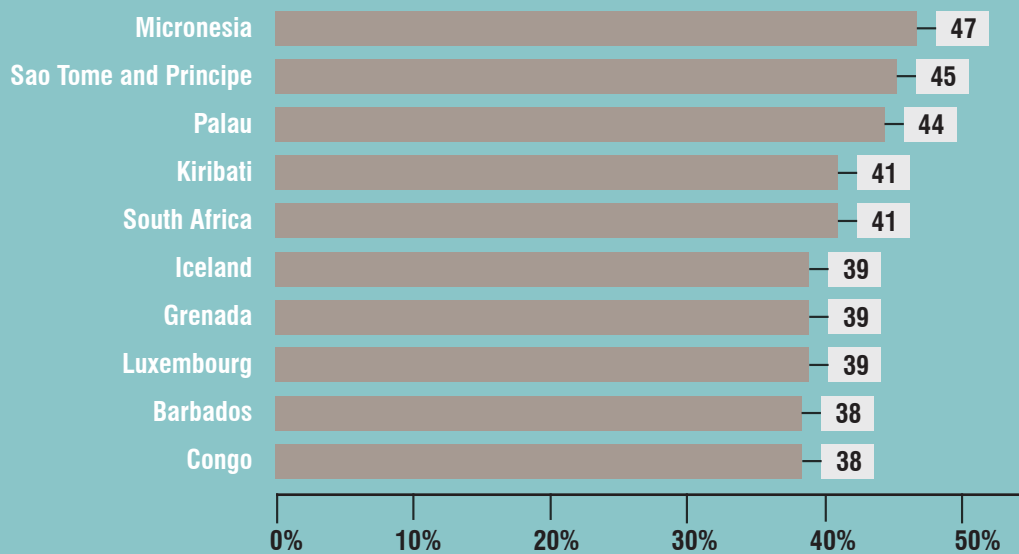
Figure 5b. The ten States that received the highest proportion of recommendations related to health

Country	Value
Micronesia	47
Sao Tome and Principe	45
Palau	44
Kiribati	41
South Africa	41
Iceland	39
Grenada	39
Luxembourg	39
Barbados	38
Congo	38
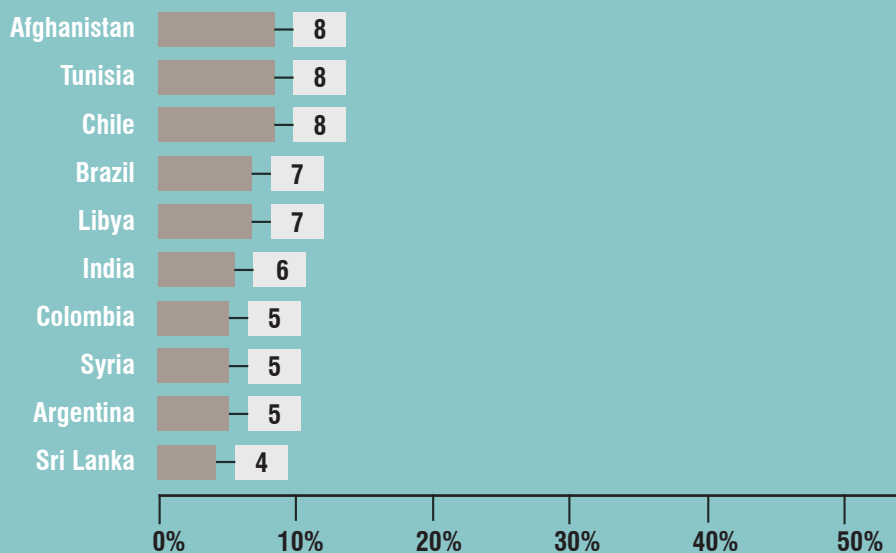
Figure 5c. The ten States that received the lowest proportion of recommendations related to health

Country	Value
Afghanistan	8
Tunisia	8
Chile	8
Brazil	7
Libya	7
India	6
Colombia	5
Syria	5
Argentina	5
Sri Lanka	4

d. The two issues that were addressed most frequently, both globally and in each WHO region, were gender-based violence and maternal, child and adolescent health. Other issues received limited attention.

Both gender-based violence and maternal, child and adolescent health issues have been widely discussed by the Human Rights Council, including in a number of Resolutions (21).

Gender-based violence undermines the enjoyment of the right to health and impedes realisation of a broad spectrum of other human rights. It was the health issue that recommendations most frequently addressed during the UPR's first cycle, and this was consistently the case across all WHO regions, although the reported prevalence of GBV varies. The highest prevalence is reported in South-East

Asia, the Eastern Mediterranean, and Africa (SEARO, EMRO, AFRO) (22). Many of the recommendations were formulated in general terms that had clear, but often implicit, implications for health.

Despite the focus on maternal health, only 28 of all health-related recommendations addressed safe abortion, and 11 of these were addressed to a single country. Most encouraged the decriminalization of abortion where it was criminalized in all circumstances.

Health recommendations during the first cycle were not balanced; a small number of issues received far more attention than others. Figure 6 below illustrates the frequency with which particular health issues were raised.

To some extent, these patterns reflect the way the

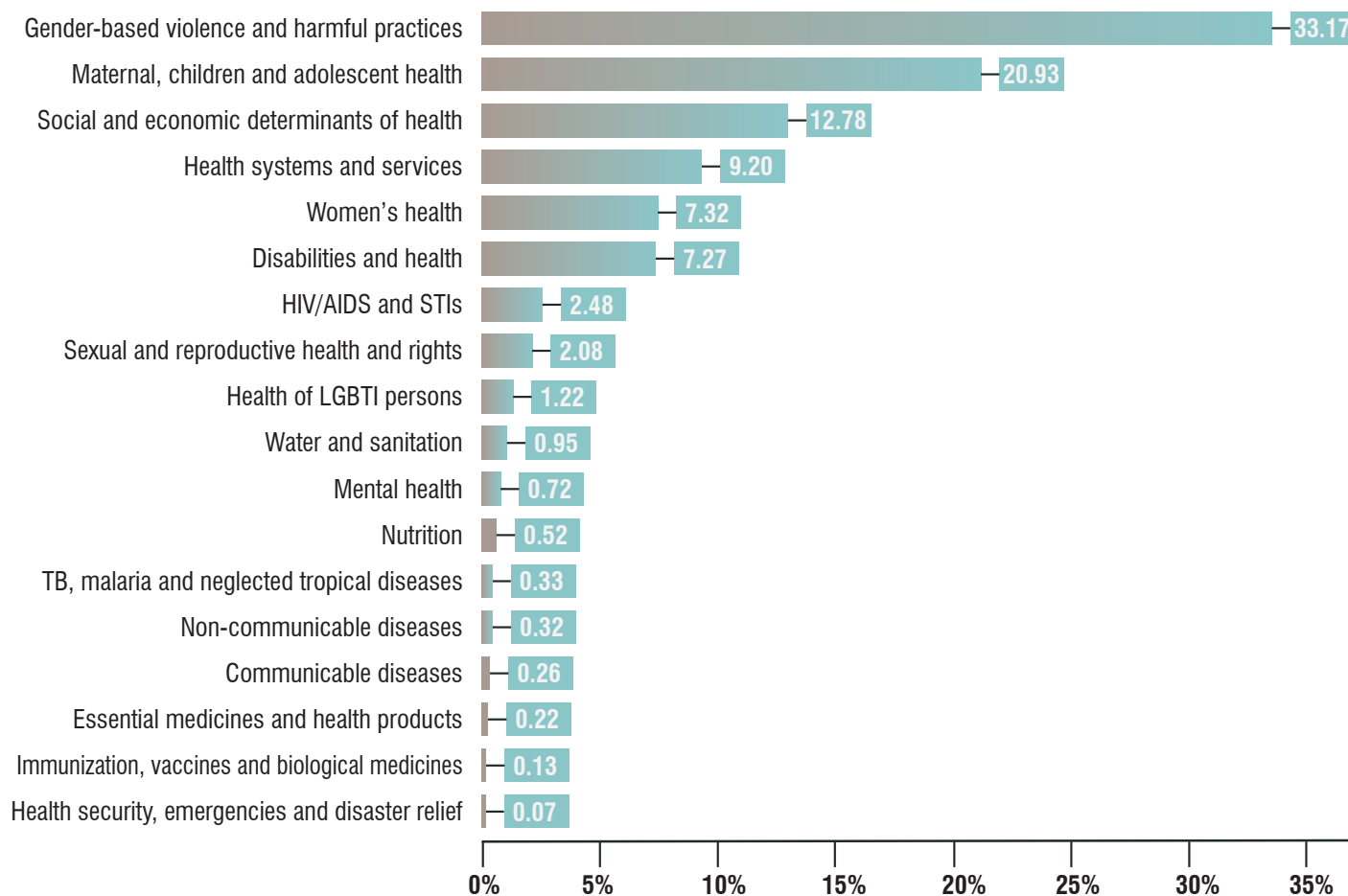## Distribution of health-related topics in the recommendations from first cycle Universal Periodic review, 2008–2012

Topic	Value
Gender-based violence and harmful practices	33.17
Maternal, children and adolescent health	20.93
Social and economic determinants of health	12.78
Health systems and services	9.20
Women's health	7.32
Disabilities and health	7.27
HIV/AIDS and STIs	2.48
Sexual and reproductive health and rights	2.08
Health of LGBTI persons	1.22
Water and sanitation	0.95
Mental health	0.72
Nutrition	0.52
TB, malaria and neglected tropical diseases	0.33
Non-communicable diseases	0.32
Communicable diseases	0.26
Essential medicines and health products	0.22
Immunization, vaccines and biological medicines	0.13
Health security, emergencies and disaster relief	0.07

Figure 6. Health issues raised in UPR recommendations during the first cycle

A healthcare professional from the US Pacific Fleet treats a child patient

project chose to categorize health issues. Because the priorities were based on WHO's programme of work, some categories covered a broader range of issues, and some issues were relevant to a wider range of countries. (Compare the breadth of maternal, child and adolescent health, for example, to nutrition, or health security, or emergency and disaster relief). For both these reasons, some health recommendations were probably concentrated in certain categories, each of which is a distinct category. At the same time, the broader categories also masked issues. For example, a separate review of recommendations on the health of adolescents showed that, compared to mothers and young children, this group was significantly underrepresented in UPR recommendations. In a similar way, as mentioned, maternal health was prominent among health-related recommendations, but lack of access to safe abortion, a leading cause of maternal mortality, and prominent human rights issue, was not.

e. The regional distribution of recommendations was largely comparable with a few exceptions.

Overall, the recommendations raised a similar pattern of issues in each of the WHO regions, with some notable differences. A higher proportion of recommendations focused on gender-based violence in the Eastern Mediterranean region, and on HIV/AIDS in the African region (possibly reflecting the scale of the epidemic in that region). Water and sanitation, overall a neglected category, featured more prominently in recommendations to African countries. Although the South-East Asia region had the second lowest rate of access to sanitation worldwide (at the time of reporting), only 4% of the health recommendations to countries in this region referred to water and sanitation.

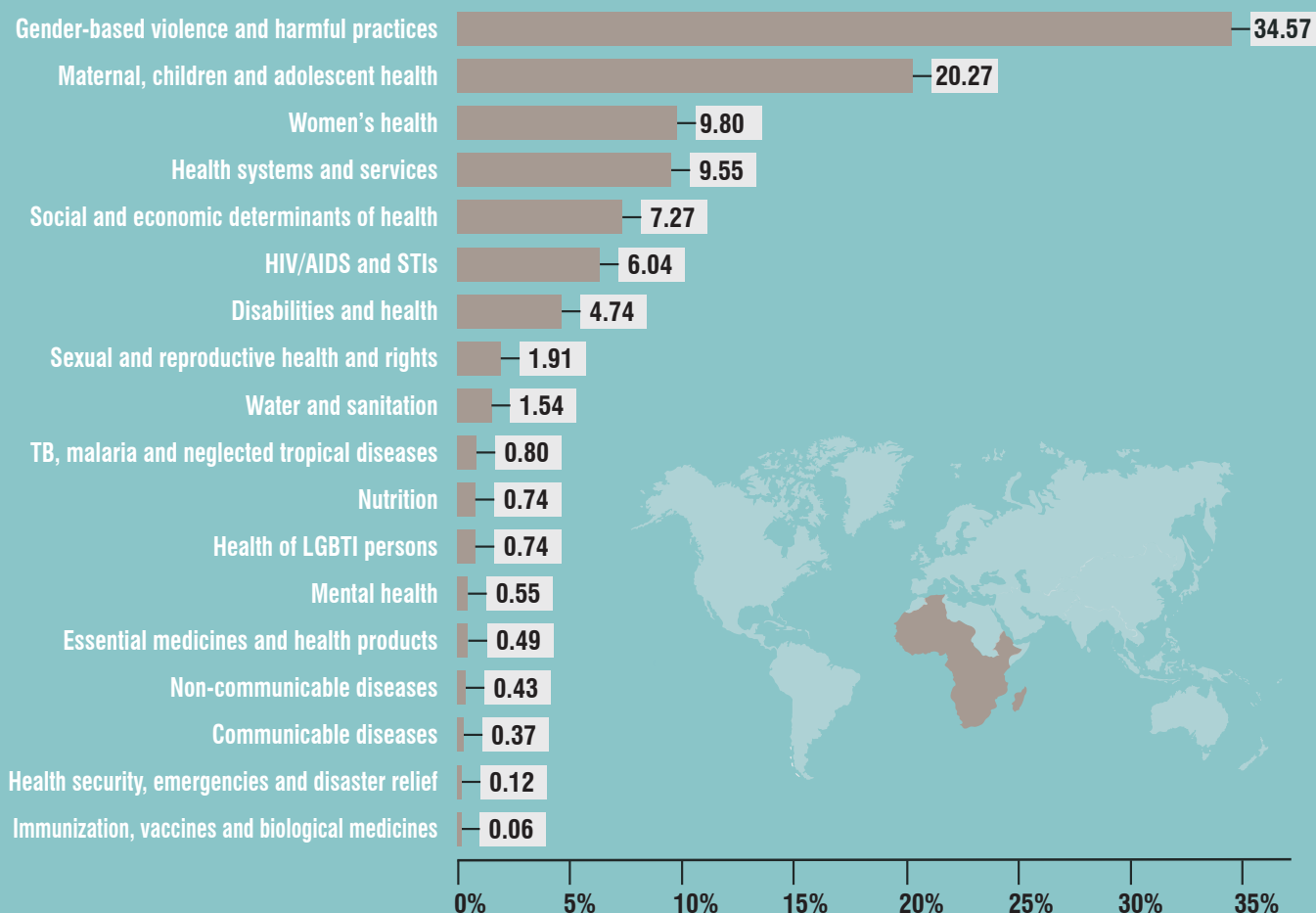**Figure 7a -7f.** Health issues disaggregated by region.

Gender-based violence and harmful practices — 34.57
Maternal, children and adolescent health — 20.27
Women's health — 9.80
Health systems and services — 9.55
Social and economic determinants of health — 7.27
HIV/AIDS and STIs — 6.04
Disabilities and health — 4.74
Sexual and reproductive health and rights — 1.91
Water and sanitation — 1.54
TB, malaria and neglected tropical diseases — 0.80
Nutrition — 0.74
Health of LGBTI persons — 0.74
Mental health — 0.55
Essential medicines and health products — 0.49
Non-communicable diseases — 0.43
Communicable diseases — 0.37
Health security, emergencies and disaster relief — 0.12
Immunization, vaccines and biological medicines — 0.06

0% 5% 10% 15% 20% 25% 30% 35%

Gender-based violence and harmful practices — 31.53
Maternal, children and adolescent health — 22.74
Social and economic determinants of health — 13.27
Health systems and services — 7.35
Disabilities and health — 7.02
Women's health — 5.92
Sexual and reproductive health and rights — 3.63
Health of LGBTI persons — 3.47
HIV/AIDS and STIs — 1.18
Nutrition — 0.68
Water and sanitation — 0.59
Mental health — 0.34
Essential medicines and health products — 0.25
Non-communicable diseases — 0.17
Communicable diseases — 0.17
Immunization, vaccines and biological medicines — 0.08
TB, malaria and neglected tropical diseases — 0.00
Health security, emergencies and disaster relief — 0.00

0% 5% 10% 15% 20% 25% 30% 35%

Health issue	%
Gender-based violence and harmful practices	35.93
Maternal, children and adolescent health	14.50
Women's health	13.42
Social and economic determinants of health	13.42
Health systems and services	12.77
Disabilities and health	6.28
Water and sanitation	1.08
Health of LGBTI persons	0.87
Sexual and reproductive health and rights	0.65
Nutrition	0.22
Communicable diseases	0.22
TB, malaria and neglected tropical diseases	0.22
HIV/AIDS and STIs	0.22
Non-communicable diseases	0.22
Health security, emergencies and disaster relief	0.22
Immunization, vaccines and biological medicines	0.00
Essential medicines and health products	0.00
Mental health	0.00

Health issue	%
Gender-based violence and harmful practices	31.60
Maternal, children and adolescent health	21.72
Social and economic determinants of health	19.84
Disabilities and health	10.32
Health systems and services	8.35
Non-communicable diseases	3.60
Sexual and reproductive health and rights	2.33
Mental health	2.15
Women's health	1.89
Communicable diseases	0.90
Water and sanitation	0.63
HIV/AIDS and STIs	0.54
Health of LGBTI persons	0.45
Immunization, vaccines and biological medicines	0.09
Nutrition	0.00
TB, malaria and neglected tropical diseases	0.00
Essential medicines and health products	0.00
Health security, emergencies and disaster relief	0.00

Health issue	%
Gender-based violence and harmful practices	34.18
Maternal, children and adolescent health	20.36
Health systems and services	14.91
Social and economic determinants of health	12.36
Disabilities and health	8.00
Women's health	3.27
Nutrition	1.45
Health of LGBTI persons	1.09
Water and sanitation	0.73
HIV/AIDS and STIs	0.73
Immunization, vaccines and biological medicines	0.36
TB, malaria and neglected tropical diseases	0.36
Essential medicines and health products	0.36
Mental health	0.36
Sexual and reproductive health and rights	0.36
Communicable diseases	0.36
Non-communicable diseases	0.36
Health security, emergencies and disaster relief	0.36

Fig 7f: Health issues raised in the WPRO region

Health issue	%
Gender-based violence and harmful practices	32.45
Maternal, children and adolescent health	22.07
Social and economic determinants of health	13.43
Women's health	9.57
Disabilities and health	8.78
Health systems and services	8.11
HIV/AIDS and STIs	1.37
Sexual and reproductive health and rights	1.06
Water and sanitation	0.66
Nutrition	0.40
Immunization, vaccines and biological medicines	0.40
TB, malaria and neglected tropical diseases	0.40
Communicable diseases	0.40
Non-communicable diseases	0.27
Health of LGBTI persons	0.13
Mental health	0.13
Essential medicines and health products	0.00
Health security, emergencies and disaster relief	0.00

f. There was a tendency to formulate health-related recommendations in non-specific and non-operational terms. Individual recommendations raised a diversity of health issues; or recommendations did not clearly specify what action is to be taken.

Individual recommendations raise a diversity of health issues

Many of the health-related recommendations in the first UPR cycle raised a variety of rights or a variety of health issues, making it difficult to separate out which, if any, issues were to be prioritized.

nevertheless, because health overlaps with other social determinants. It requires well-coordinated government to deliver health programmes effectively (especially when issues require contributions from different ministerial portfolios).

Recommendations do not clearly specify what action is to be taken

The impact and value of the UPR process would increase if recommendations were more carefully drafted to focus on implementation and realizable outcomes. Many of the recommendations from the first cycle were cast in broad and non-specific terms.

Examples of health-related recommendations formulated in non-specific terms

> " Continue advancing in its efforts to achieve universal coverage of its Maternity, Disease and Health Care Programme "

> " Country X (should) continue and strengthen its efforts in the field of economic, social and cultural rights, in particular in the field of health "

Preliminary findings suggest that, where recommendations addressed multiple issues, they have been implemented less often or less fully. This finding makes intuitive sense. Bundling a variety of concerns together is likely to make delivery of all parts of the recommendation more difficult. For instance, a recommendation that touches on health, education, and housing sectors likely requires coordination between at least three different Ministries and institutions in three sectors. Bundling is often necessary and is inevitable,

If the language of recommendations is too broad, implementation and reporting are likely to be unsatisfactory because it will be unclear what specific action was expected, whether actions were appropriate, or how to measure or value the results. Other reviews of the UPR have also raised concerns about non-specific recommendations. According to the Center for Economic and Social Rights, recommendations on economic, social and cultural rights were particularly likely to be unspecific. Recommendations on civil and political rights were more frequently precise (23).

After reviewing the recommendations made during the first UPR cycle, the project assessed and compared the recommendations made to eight countries during the second UPR cycle.

We also examined patterns of implementation among the eight countries of recommendations made in the first cycle. The countries were selected from all six WHO regions: Cambodia, Chile, Jamaica, Lebanon, Malawi, Moldova, Mozambique, and Nepal. The findings of this review are discussed below.

In a final phase of research, presented at the end of this section, we also report some preliminary findings regarding all health-related recommendations made to all countries in cycle 2.

a. The number of health-related recommendations continued to rise during the second cycle in the eight-country subsample.

Health continued to be a prominent theme in UPR recommendations throughout the second cycle. In the eight countries reviewed, 20% of recommendations in cycle 1 and 26% of recommendations in cycle 2 were health-related.[19] Although the country sample was small, this suggests that health was more prominent in the second cycle, a finding corroborated by the Center for Economic and Social Rights (24). More significantly, because the volume of recommendations increased, so did the number of recommendations relating to health. The number more than doubled in the countries reviewed.[20]

792 203

20,40%

First cycle

1202 432

26,44%

Second cycle

■ Health-related recommendations

■ Non health-related recommendations

Selected countries Cambodia, Chile, Jamaica, Lebanon, Malawi, Moldova, Mozambique, and Nepal
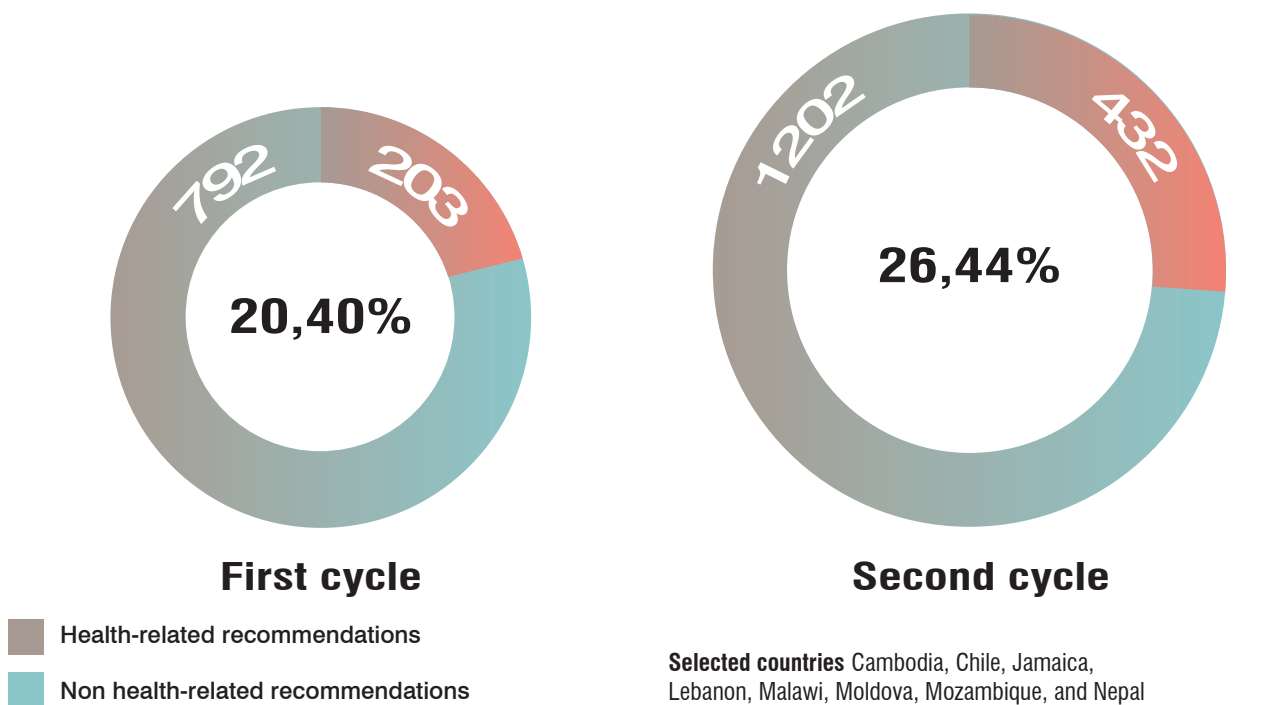
Figure 8. Distribution of health and non-health related recommendations in first and second cycles (8 countries)

19 In individual countries, the proportion of health-related recommendations varied significantly – from 9% (Cambodia) to 33% (Mozambique) in cycle 1, and from 15% (Cambodia) to 33% (Jamaica) in cycle 2.
20 The total number of recommendations made to the eight countries increased between the two cycles from 995 to 1,634; the number of health-related recommendations more than doubled, from 203 to 432.
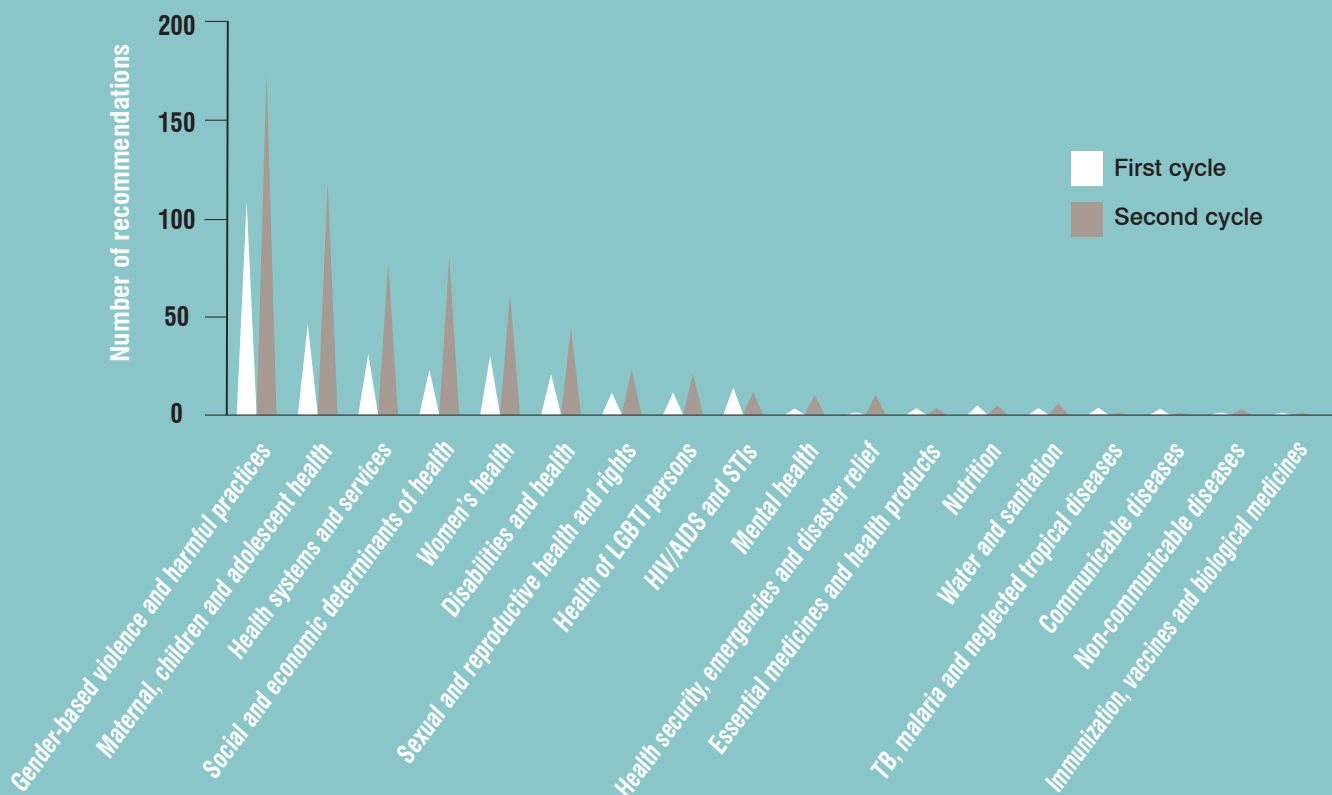
Figure 9. Number of recommendations for both cycles by health category (8 countries)

As in the first cycle, a narrow set of health categories continued to dominate. In the second cycle, these issues were gender-based violence, maternal and child health, health services, and social and economic determinants. Other health categories (vaccinations, communicable and non-communicable diseases, nutrition) were mentioned in few or no recommendations to the reviewed countries.

The most prominent issues received similar levels of attention in the two cycles. The number of recommendations on gender-based violence, maternal and child health, social and economic determinants, and health system strengthening increased significantly.

b. Few (accepted) health-related recommendations were fully implemented; the majority of States reported that a significant proportion of (accepted) recommendations had been 'partially' implemented.

In the first cycle, the eight selected States accepted 61% of the health-related recommendations that were made to them. Using the mid-term implementation assessment scale developed by UPR Info,[21] only 15% of these were recorded as 'fully implemented' two years later; 46% were 'partially implemented'. This suggests that States took at least some steps to fulfil the UPR recommendations they accepted in the first cycle. The States nevertheless reported that 39% of the health-related recommendations they accepted in the first cycle had not been implemented at all after 2 years.

This response must be read in context, because the rate of implementation across all recommendations was also low. A review in 2014 by UPR Info concluded that the recommendations most likely to trigger action were those on HIV/AIDS, and that health recommendations were among the recommendations that were most frequently addressed (25).

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21 UPR Info developed a three-tier assessment of recommendations that were 'fully implemented', 'partially implemented', and 'not implemented'. For more on its methodology, see: https://www.upr-info.org/followup/.

c. The majority of health-related recommendations continued to raise health in conjunction with other issues (education, housing, nutrition); but more than one third targeted health issues specifically.

The project's analysis of the second cycle determined that health-related recommendations fell into three groups: those that 'included health' (mentioned health issues alongside other issues); those that were 'health-general' (focused on general health issues), and those that were 'health-specific' (focused on a particular health category).

In the eight countries reviewed, 55% of health-related recommendations 'included health' in conjunction with other areas of concern (such as education or housing); 36% were "health-specific" (focused, for example, on HIV/AIDS or domestic violence); and 9% were 'health general' (focused on health but without specifying particular health issues).

Health-general and health-specific recommendations were implemented to a similar extent. Within the 46% of all health-related recommendations reported to have been at least partially implemented, almost a third of health-specific and health-general recommendations reported partial implementation, mirroring the pattern of the first cycle. Relatively few (16%) of the recommendations that included health with other issues were fully implemented. This suggests that, while states were responsive to recommendations that 'included health', full implementation was more complex.

d. In the main, health-related recommendations reflected the health information contained in the three UPR background documents prepared before each country review.

The eight country review also examined the degree to which recommendations made to States during the second UPR cycle reflected or were influenced by the three background documents that are prepared before each UPR review and submitted to the Working Group. The three documents are: a country report;[22] a stakeholder summary;[23] and a UN submission.[24]

There was a discernible correlation between the number of paragraphs devoted to particular health issues in the three background documents, and the incidence of those health issues in subsequent recommendations. As a general trend, health issues to which the reports gave significant attention (maternal, child and adolescent health, gender-based violence and other harmful practices, and health systems and services) were frequently mentioned in recommendations; conversely, issues to which the reports gave limited attention (such

> "There was a discernible correlation between the number of paragraphs devoted to particular health issues in the three background documents, and the incidence of those health issues in subsequent recommendations"

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22 Each State under Review is required to prepare a country report. Country reports provide information on the general human rights situation in the country, highlight successes, and identify areas in which the country seeks assistance and improvement. States are expected to compile country reports through a participatory process that involves a range of government ministries and agencies, civil society organizations, and national human rights institutions.
23 Stakeholder summaries are compiled by OHCHR on the basis of documents submitted by civil society organizations and national human rights institutions. As might be expected, these reports are more critical of the State than country reports.
24 UN submissions compile issues that have been raised (including recommendations to the State concerned) by UN Treaty Bodies and Special Procedures, as well as information provided by UN bodies, including the local UN Country Team.

as vaccines, and tuberculosis) were rarely listed in recommendations. However, certain categories appeared to defy this trend. Sexual and reproductive health and the health of persons with disabilities received less attention in recommendations than would have been anticipated given the degree of attention given to them in the reports submitted for review.

On certain issues, there were marked disparities between the priorities accorded by country reports, stakeholder reviews and UN submissions. The most evident example concerned lesbian, gay, bisexual, transgender and intersex-related health issues. During the two cycles, LGBTI issues were raised 33 times in recommendations to the eight countries reviewed, yet only one country report mentioned this subject; in contrast, stakeholder reports frequently raised LGBTI issues. Similarly, in both cycles mental health was the sixth most frequently raised health issue in country reports (by the eight countries reviewed), but the 12th most discussed category in UN submissions. Mental health was subsequently listed in only 12 recommendations.

These findings, while not conclusive, suggest that some reports have more influence on the pattern of recommendations than others, particularly when (like the issue of LGBTI health) the subject is ideologically or politically sensitive in some quarters. At the same time, it is difficult to pinpoint when or even whether one type of report is more influential than the other two. The analysis also suggests that reviewing states are simply less interested in some health issues, regardless of how prominently they feature in the UPR background documentation.

Number of countries (out of 8) where each health category was covered by both the UPR recommendations and the UNDAF, only the UNDAF, or only the UPR recommendations
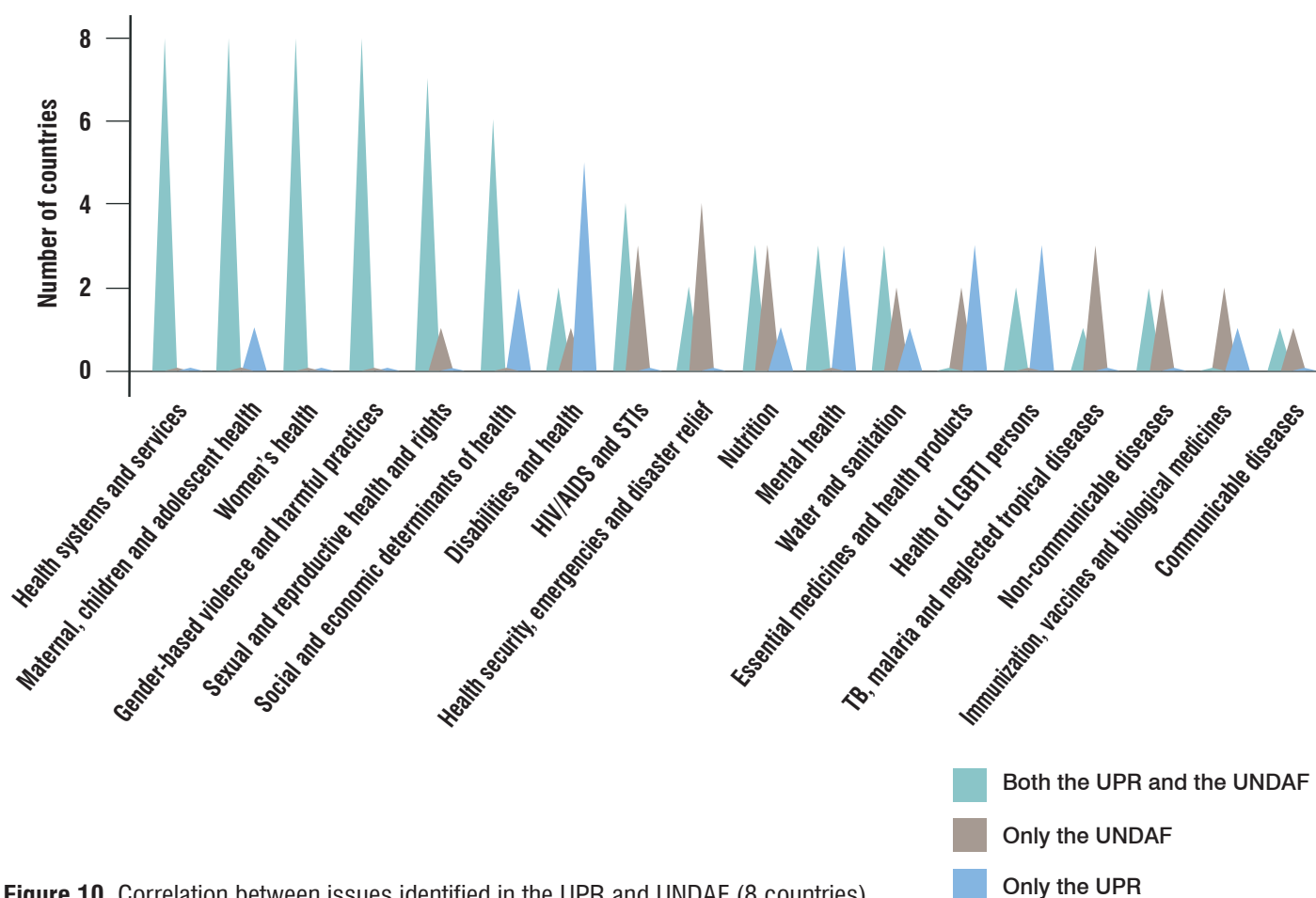
Figure 10. Correlation between issues identified in the UPR and UNDAF (8 countries)

Both the UPR and the UNDAF

Only the UNDAF

Only the UPR

Eight countries is a small sample, and it would be desirable to establish whether a larger sample would reveal the same congruences and disparities, or indicate more clearly how the UPR background documents influence the focus of health-related recommendations. The review suggests that many variables probably influence the coverage of reviewing states; this question too merits further exploration. However, if the trends suggested by this review were to be confirmed, WHO and other stakeholders might be able, in cooperation with UN agencies and reviewing states, to influence the attention that specific health issues receive in the UPR. Even though the exact process by which issues come to be listed in recommendations is not precisely discernible, the findings underscore the value of considering a range of viewpoints and priorities and different reporting sources.

e. Health priorities identified in UPR recommendations broadly reflect the priorities of UN Development Assistance Frameworks (UNDAFs).

UNDAFs set out the priorities of UN development assistance in a country; and also reflect the priorities that have been determined nationally. The extent to which UPR recommendations align with UNDAF priorities is therefore a useful indicator of the relevance of UPR recommendations to identified global health priorities. In some cases, UPR recommendations may also signal that UNDAFs need to address certain issues more fully.

Figure 10 shows the number of health categories (in the eight countries under review) that: (1) the UNDAF and UPR recommendations both covered; (2) only the UNDAF covered; and (3) only the UPR covered.

Gender-based violence was addressed by both the UPR and the UNDAF in all eight countries reviewed. Health services and systems, gender, and maternal, child, and adolescent health were covered by both documents in seven out of eight countries. In contrast, some categories – namely, mental health, essential medicines and health products, health of persons with disabilities, and LGBTI health issues – were

more likely to be addressed by the UPR only. Several factors might explain these differences, among them the sensitivity of certain issues in some Member States, and the nature of national and international prioritization processes and targets, some of which distort the balance of health and development policies. Further analysis is required to determine more specifically the underlying influences on these patterns.

f. Preliminary analyses of all recommendations made to all countries during the full second cycle indicate that the proportion related to health was broadly comparable between the two cycles.

Subsequent to the completion of the second phase of this study (i.e., the eight-country study), the study methodology was repeated for all recommendations made to all countries during the second cycle, not just the eight country subsample. This analysis was conducted primarily in order to identify the degree of continuity between the first (2008-2012) and second (2012-2016) UPR cycles, specifically with regard to the number health-related recommendations and the categories of health that they covered.

> **During the second UPR cycle, there was a total of 33,956 recommendations made to all states on all topics, which was more than double the 17,638 made during the first UPR cycle**

During the second UPR cycle, there was a total of 33,956 recommendations made to all states on all topics, which was more than double the 17,638 made during the first UPR cycle. Of these 33,956 recommendations, the research team coded 8,356 of the second cycle recommendations as being health-related, using the same criteria applied in the earlier phases of the study. This figure was a near doubling in absolute numbers of health-related recommendations from the first UPR cycle, in which there were 3,862 health-related recommendations.

There was also a modest increase in the proportion of all recommendations that related to health, rising from 21.90% in the first cycle to 24.61% in the second cycle, an increase of 2.71 percentage points. This indicates some growth in emphasis on health in the second cycle, although not a dramatic increase.

g. Preliminary analyses of the health categories covered by all recommendations made to all countries during the full second cycle indicate that the same health categories were prioritized during both of the cycles.

The most common health category in both the first and second cycles was gender-based violence, representing about one-third of all health-related recommendations in both cycles. The other top-two categories were maternal, child, and adolescent health and social and economic determinants of health. Between the two cycles, there was a relative decrease in the focus on maternal, child, and adolescent health (20.93% in the first cycle vs. 18.53% in the second) and a relative increase in the focus on social and economic determinants (12.78% in the first cycle vs. 19.64% in the second).

Similar stability was seen in the next-highest three categories: health systems and services (9.2% in first cycle vs. 8.54% in the second; women's health (7.32% in the first cycle vs. 6.96% in the second); and the health of people with disabilities (7.27% in the first cycle vs. 6.16% in the second).
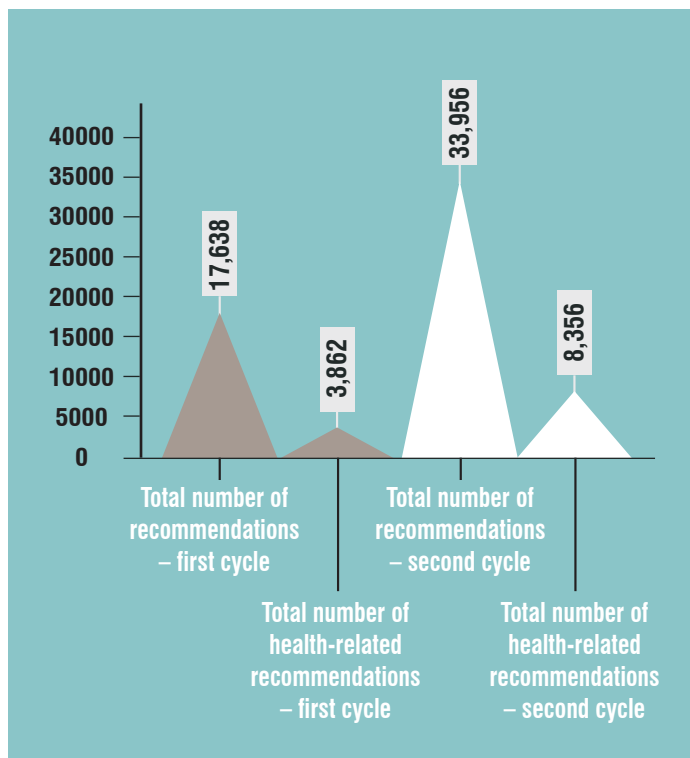
Figure 11. Total numbers of health-related recommendations in the first and second UPR cycles
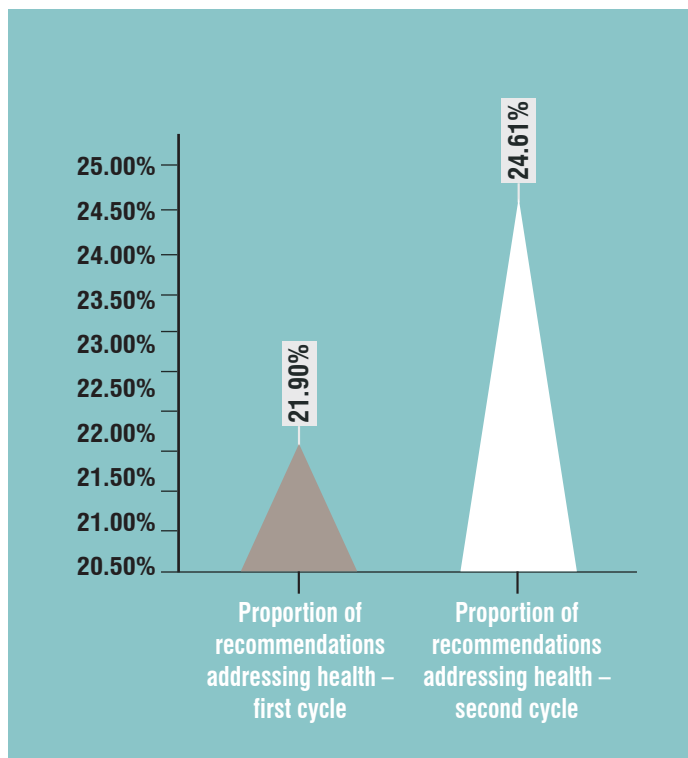
Figure 12. Proportion of recommendations addressing health in the first and second UPR cycles

Strikingly, the remaining twelve health categories collectively continued to represent around 10% of all health-related recommendations (9.33% in the first cycle, and 10.22% in the second). As noted above, some of this striking disparity may be attributed to differences in the scope of each category as defined within this study, with some categories being notably broader than others. However, this effect was mitigated by the practice of counting all health categories mentioned in each recommendation.

In the context of a global process including all 192 UN Member States, it is also worth noting that a number of important health categories received only a tiny number of recommendations in absolute terms. For example, out of 8,356 recommendations made on all health topics throughout the second cycle, a mere 10 recommendations raised the issue of immunization and vaccines, only 19 mentioned TB and malaria, and just 24 presented concerns about essential medicines. Several health categories that are directly germane to achievement of the UN Sustainable Development Goals, including non-communicable diseases, mental health, and nutrition each were included in 77 or fewer recommendations.
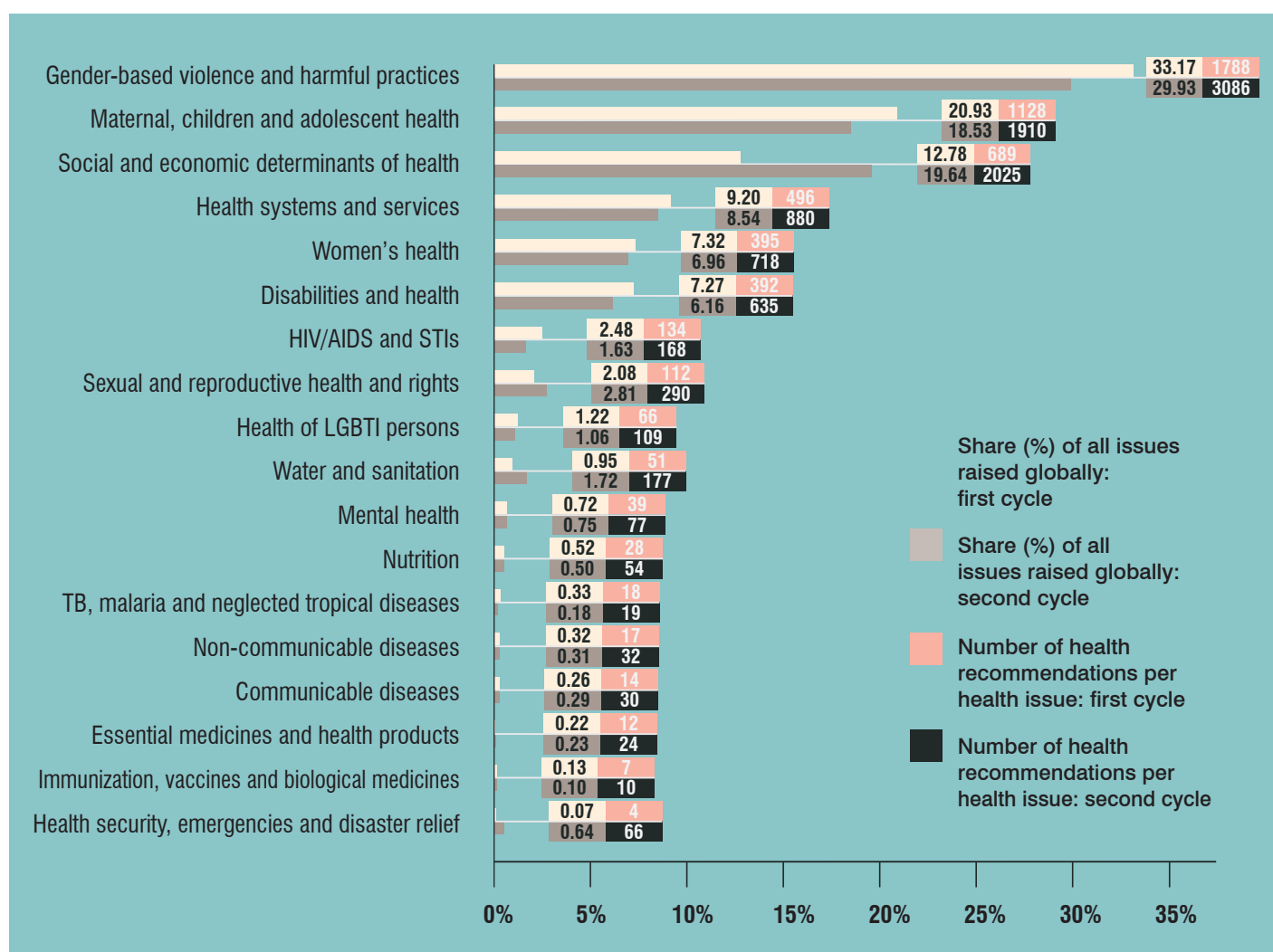
Figure 13. A comparison of health-related recommendations addressing each health category during the first and second UPR cycles

PART FOUR

Discussion: Insights from the analyses of the first and second cycles

The findings presented above have important implications for the way multilateral organizations and other stakeholders engage with the UPR process. They have a bearing on reporting, on briefing processes and the preparation of background materials, on how recommendations are crafted and prioritized, and on the support given to follow-up and implementation. These implications are discussed below.

1. The prominence of health as a rights issue under the UPR.

In the first UPR cycle, 21.90% of all recommendations were health-related; in the second cycle, this figure rose by 2.71 percentage points to more than 24.61%. The absolute number of health recommendations also more than doubled between the first and second cycles, mirroring a significant rise in the overall number of recommendations.

These findings demonstrate that countries are extensively and explicitly including health-related issues in the UPR accountability process. Though the spread of health issues addressed is still limited, the UPR process clearly has the potential to advance health in countries, frame health issues in 'rights' terms, and galvanize cross-sectoral and UN-wide action.

2. Health-related recommendations were skewed in favour of a small number of health issues.

Across both cycles, the same three issues were most frequently cited in recommendations: gender-based violence, maternal, child and adolescent health, and social and economic determinants of health of persons with disabilities. Conversely, a number of health issues arguably received insufficient attention (in relation to WHO and UNDAF priorities): they included nutrition, communicable diseases (other than HIV/AIDS), non-communicable diseases, mental health, and access to medicines.

This pattern suggests that reviewing States prioritize certain health issues because they are considered key 'rights' issues, but perhaps do not prioritize others that health specialists consider critical. Some issues (for example, malaria or non-communicable diseases) may be overlooked because they have not been framed as human rights concerns. However, in other cases (including access to medicines, mental health, and abortion), the human rights dimensions are clear and well documented. This hints at the differential influence on State positions of, for example, lobbying, information, evidence and politics.

Nevertheless, if the UPR process is to fulfil its aspiration to be truly universal, it will be important to better understand the drivers and processes involved in the selection of issues put forward as recommendations. Currently, there appear to be some gaps and inconsistencies in the priorities made that will need to be addressed . Multilateral organizations, national stakeholders and Special Procedure mandate holders can all contribute to redress the balance, by ensuring the provision of up to date and impartial information on country situations.

3. There is a broad correlation between the content of the background information submitted to the UPR working group (the country report, stakeholder summary and UN submission) and the number and content of recommendations.

In an eight-study subsample, the review identified a congruence between the space devoted to health issues in the three UPR background documents, and the attention devoted to the same health issues in subsequent recommendations. However, some issues, including mental health and LGBTI, did not follow this pattern. This too suggests that practical, political and ideological constraints have a determining effect on the inclusion of these issues, irrespective of their urgency in health terms.

The sample size of this part of the study was too small to determine which of the three background documents submitted to UPR Working Groups has most influence on the focus and number of health-related recommendations. Further research is needed to clarify that question.

4. Nearly half of all health-related recommendations are 'partially implemented' (46%).

Within the eight-country subsample, there was substantial variation in the degree of implementation of first-cycle recommendations that had taken place within two years. While nearly half of all health-related recommendations were reported as 'partially implemented', well over a third (39%) of health-related recommendations to which States had agreed had not been implemented and just a quarter had been fully implemented (15%).

At the same time, the findings suggest that a more expansive or nuanced means of assessing the implementation of UPR recommendations might be helpful. Such means might include not only States' principal health outcome indicators (e.g., maternal mortality, etc.), but also other

qualitative research as well as assessments of legal environments.

The UPR cycle moves from reporting to reviewing and recommendations and then implementation and monitoring, before repeating. The initial pre-review reporting phase, which essentially takes place at country level, provides an opportunity for State, UN and non-State stakeholders to make inputs on key health issues. It is an opportunity for WHO, and UN country teams more generally, to work with other stakeholders and the Government to ensure that adequate attention is given to the most pressing health issues. This might involve identifying and filling gaps in the three background documents as they are prepared, and more generally strengthening and sharpening their descriptions of health needs and health categories.

Participating in the various dialogues at national level that precede preparation of the reports would permit WHO to meet and engage with stakeholders and sectors, including those most directly involved in the UPR process, such as Ministries of Foreign Affairs, civil society organizations and national human rights institutions. These inputs could be mirrored at global level. UN agencies are invited, as a matter of course, to submit reports in relation to their mandate and to attend relevant meetings in Geneva on behalf of their organizations. To date, however, very few agencies have done so. WHO's normative expertise could helpfully inform and focus health-related UPR recommendations, by including evidence-based information on interventions that are known to improve health outcomes. This would constructively improve UPR recommendations, in accordance with WHO's mandate to assist Member States to achieve the highest attainable standards of health.

At the same time, the information collected for the UPR process can provide valuable quantitative and qualitative data, which may help to advance the realization of national, WHO and UNDAF health priorities.

PART FIVE

Conclusions: Implications for engaging on health in the UPR

For a decade, the Universal Periodic Review process has been the Human Rights Council's principal forum for reviewing the human rights performance and needs of States. It is a peer-driven process that generates a large number of human rights recommendations. As such, it offers a unique opportunity to identify and highlight important health-related human rights issues and generate corresponding action and attention on the ground. As the third cycle has taken shape, many commentators have rightly focused attention on the need to ensure that recommendations are implemented and followed up. However, so far, rather little work has been done to evaluate how well the UPR has managed its ambitious mission to assess human rights comprehensively and inclusively. This report has sought to examine the extent to which the right to health (one of many norms in the International Bill of Rights) was addressed during the first and second UPR cycles, whether the coverage was adequate and matched nationally-agreed priorities, what gaps exist, and what opportunities there may be to improve the attention given to health.

While the research described here is far from exhaustive, it provides some insights into how the UPR has addressed health from a rights perspective. It has exposed some flaws in the process and some untapped opportunities, and has also revealed a number of positive trends. A significant proportion of recommendations already touch on health-related issues; those issues could be covered more fully than they have been, and their focus could be sharpened.

Second, the UPR mobilizes a wide variety of ministries and civil society organizations. Framing health issues as rights draws the attention of a wide audience to them and
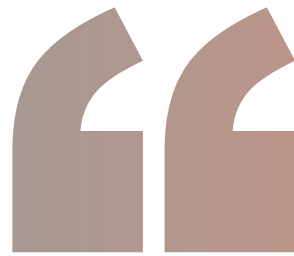
> **The UPR offers a new national and global space to discuss, constructively, how to improve efforts to realize the right to health**
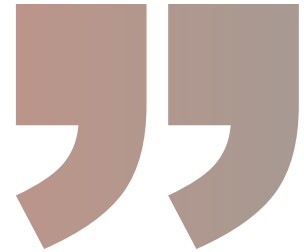
puts them in a fresh light. There are many opportunities for the WHO and other UN agencies to contribute usefully to the UPR process at country level as well as in Geneva.

The prominence of health rights in the first two UPR cycles creates opportunities for organizations engaged in global public health to support implementation of these recommendations at country level and draw sustained attention to them at global level. As the volume of overdue reports to other human rights mechanisms accumulates, the UPR offers a new national and global space to discuss, constructively, how to improve efforts to realize the right to health.

Finally, the analysis shows that the current reporting process is in many ways skewed. It tends to focus on a narrow range of health issues, most of which are aligned with national priorities, but some of which are not and may be driven by other agendas. Organizations, including WHO, which is well positioned to support and enrich the UPR process, could do more to ensure that UPR reviews are comprehensive in their analysis of essential health issues, and in the recommendations they make to States.

1 UPR BACKGROUND

The UPR was introduced in 2010, under UN General Assembly resolution 60/252 which mandated the Human Rights Council to "undertake a universal periodic review, based on objective and reliable information, of the fulfilment by each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States".[25]

Formally established by the Human Rights Council under Resolution 5/1, the Universal Periodic Review is a universal peer review mechanism that sequentially examines the human rights record of each State. The review focuses on fulfilment of state obligations under the UN Charter, the Universal Declaration on Human Rights, human rights treaties ratified by the State under Review, voluntary pledges and commitments made by the State, and applicable international humanitarian law.[26]

The UPR mechanism was designed to review, "based on objective and reliable information the fulfilment by each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States". In addition, its transparent and participatory review process provides States an opportunity to share best practices, and highlight the capacity-building needs of States as well as the challenges they face in meeting their human rights obligations.

The UPR process is managed by the Working Group of the UPR, which consists of the 47 Member States of the Human Rights Council. However, every UN Member State is entitled to make recommendations at UPR sessions. Each UPR review is based on three documents circulated in advance of the interactive dialogue: a State report, a stakeholder summary, and a UN compilation. A 'troika' of three States manages each review, serves as rapporteur of the review process, and prepares an outcome report. The outcome report consists of the questions and comments that were put to the State under Review, as well as recommendations made by States. The State under Review may 'note' or 'accept' recommendations; a State is expected to be accountable for its progress towards implementing recommendations which it has accepted.

The first UPR cycle ran from 2008 to 2012. There were 12 sessions in total, with 16 countries reviewed in each session. The second UPR cycle drew to a close in 2016, having commenced in 2012.

> "The UPR was introduced... to undertake a universal periodic review, based on objective and reliable information, of the fulfilment of each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States"

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25 For more, see General Assembly Resolution 60/251, 3 April 2006, establishing the Human Rights Council.
26 For more, see UPR Info, *What is the UPR?* http://www.upr-info.org/en/upr-process/what-is-it.

2 PROJECT AIMS AND METHODS

In 2015, the WHO and the Human Rights Centre Clinic of the University of Essex initiated a two-year collaborative research project on health-related rights and the Universal Periodic Review. It aimed to:

- Assess how frequently, and in what ways, health was addressed in recommendations made to States by the UPR Working Group.
- Understand how to position and support a stronger focus on accountability for progress towards health-related human rights.
- Identify entry points and guidance for WHO staff to engage more routinely and effectively with the mechanism to advance government and partner commitments towards the right to health, as an issue of pressing concern to the realization of human rights.[27]

The review analysed several aspects of the UPR process and how it has addressed and advanced health. In particular, it looked at:
- The frequency of health-related recommendations to States under Review.
- Which specific health issues were most frequently addressed, and which were underrepresented or neglected.
- What types of actions health-related recommendations requested States to take (legislative, policy, engagement with the international human rights machinery, etc.).
- The degree to which health-related recommendations were implemented.
- The degree to which there was synergy between the health-related recommendations of the Working Group and the priorities of the UN country team in a given country, as reflected in the UN Development Assistance Framework (UNDAF).

Full first cycle review

The project reviewed and categorized all the recommendations made to all UN Member States during the first cycle of the UPR (2008-2012). The review addressed the following questions:

- To what degree did UPR recommendations address health-related human rights?
- Which health issues were most frequently addressed and which were neglected?
- What types of actions were recommended??
- What, if any, trends were discernible in the recommendations made or received (in terms of regional patterns, types of recommendation, or themes)?

In-depth review of eight countries during the first and second cycles of the UPR.

The project reviewed and compared the recommendations issued in relation to eight selected countries during the first and second UPR cycles. The countries were: Cambodia, Chile, Jamaica, Lebanon, Malawi, Moldova, Mozambique, and Nepal. They were selected to provide a balance between WHO regions, levels of development, and types of major health concern. The research team compared the recommendations from both cycles to see:

- Whether health recommendations increased or decreased between the first and second cycles.
  Whether the same or different health issues were addressed.
- What patterns of implementation could be detected; and the degree to which the recommendations aligned with the priorities of governments, UN agencies, and civil society stakeholders.

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27 The research was carried out by two teams. Each included four postgraduate students of human rights at the University of Essex, who worked under the joint supervision of the Deputy Director of the Human Rights Centre Clinic and the Technical Officer for Human Rights, Gender Equity and Rights Team, WHO.

Responding to health needs of vulnerable population in Cox's Bazar, Bangladesh

Our subset of eight countries was a small sample. The findings cannot therefore be generalized across all UN Member States. However, they provide a cross section of data that can be scrutinized to identify possible trends in the way the UPR addressed human rights-related health issues during its first two cycles. This information could be useful when reviewing UPR recommendations to other countries, or studying a larger sample of countries. By design and intent, this element of the study was exploratory.

The second UPR cycle concluded during year 2 of the study. This report is therefore one of the first to analyse comparatively the coverage of health issues in cycles 1 and 2 of the UPR. In our discussion above of the evolution of UPR health-related recommendations, we provide some preliminary analyses of the overall number and categories of health-related recommendations made during the second cycle. We hope that future analyses will extend the reach and scope of our findings.

> " The findings cannot be generalized across all UN Member States. However, they provide a cross section of data that can be scrutinized to identify possible trends in the way UPR addressed human rights-related issues during its first two cycles "

ANNEX

For the 18 health categories, the project examined the relationship between UPR recommendations and three UPR background documents: the country report, the stakeholder report, and the UN compilation. The figures in this table are with reference to the eight-country subsample and indicate the number of paragraphs in each document that made reference to each health category.

Recommendation Categories/ health Issue	Country report	Stakeholder report	UN compilation	Number of health-related recommendations in corresponding category
Health systems and services	109	91	66	102
Health security, emergencies and disaster relief	13	6	2	12
Non-communicable diseases	12	7	3	3
Communicable diseases	7	9	6	3
Sexual and reproductive health and rights	30	29	35	33
Mental health	37	20	11	12
Social and economic determinants of health	41	55	59	102
Gender-based violence and harmful practices	83	91	112	284
Women's health	48	52	57	91
Maternal, children and adolescent health	114	93	142	163
Essential medicines and health products	17	7	14	6
Disabilities and health	31	28	14	64
Health of LGBTI persons	1	33	13	33
HIV/AIDS and STIs	24	11	15	26
TB, malaria and neglected tropical diseases	8	0	5	4
Immunization, vaccines and biological medicines	10	1	1	1
Water and sanitation	26	23	17	9
Nutrition	27	15	11	10

4 HEALTH CATEGORIES

The following health categories were identified. While they broadly reflect the WHO Organigramme in 2016, some categories (such as communicable diseases or sexual and reproductive health) were separated out into distinct health topics (e.g., HIV or violence against women) to reflect the far higher prominence of these issues among the health-related recommendations.

The categorization of health issues took the WHO's General Programme of Work as a starting point, but broke this down to more broadly reflect the key health topics dealt with across WHO's departmental structure,[28] in order to identify opportunities where rights and health complement one another in different fora (see Figure 3 on pg 12).

Health systems and services

In 2007 the World Health Organization (WHO) proposed a framework describing health systems in terms of six core components or 'building blocks': (i) service delivery and safety; (ii) health workforce; (iii) health statistics and information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/ governance.

Health security, emergencies, and disaster relief

This category relates to health in the context of humanitarian, emergency and disaster relief in order to reduce avoidable loss of life and the burden of disease and disability. Emergencies include any event that may have negative consequences for human health including events that have not yet led to disease in humans but have the potential to cause human disease through exposure to infected or contaminated food, water, animals, manufactured products or environments. Emergencies are situations impacting the lives and well-being of a large number of people or significant percentage of a population and requiring substantial multi-sectoral assistance. For WHO to respond, there must be clear health consequences.

Non-communicable diseases

The four main types of noncommunicable diseases (NCD) are cardiovascular diseases (like heart attacks and stroke); cancers; chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma); diabetes; alcohol and drug use. But this category also includes other types of NCD.

Communicable diseases

Communicable diseases comprise both infectious diseases and zoonotic diseases. Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans.

28 See: http://www.who.int/topics/en/.

Sexual and reproductive health (SRHR)
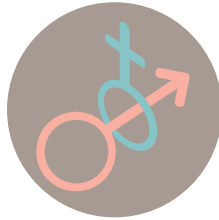
Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Reproductive health is concerned with a state of physical, mental and social well-being in relation to sexuality, as well as the reproductive processes, functions and system at all stages of life. Examples include the freedom to decide if, when, and how often to engage in sexual activity; the right of men and women to be informed about and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice; and the right of women to access appropriate health care services that will enable them to go through pregnancy safely.

Mental health

Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

Social and economic determinants of health
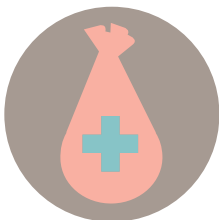
The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The Sustainable Development Goals (SDGs) provide a comprehensive blueprint for human development and for systematically addressing the social determinants of health.

Gender-based violence and harmful practices

This category includes any violence which has been perpetrated against another based on their sex, gender identity and expression, or their sexual orientation, as well as harmful practices such as female genital mutilation (FGM), female infanticide, sex-selective abortions, forced and early marriage, honour crimes or killings, polygamy, wife inheritance, virginity tests, breast ironing and similar practices.

Women's health

This category is concerned with any health recommendation relating to women's health, which was not linked to violence or SRHR, but rather addresses general health through a gendered lens. Recommendations classified here include the ratification of CEDAW.

Maternal, child and adolescent health

This category covers issues relating to maternal, foetal, newborn, infant, child and adolescent health. Also included in this category are recommendations relating to the ratification of the Convention on the Rights of the Child (CRC) and its optional protocol regarding the sale of children.

Essential medicines and health products

The issue of essential medicines covers the availability of essential medicines within the context of functioning health systems. Ideally, essential medicines are available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.

Disabilities and health

Disability is an umbrella term for impairments, activity limitations and participation restrictions. This category includes any issue that relates to persons with disabilities and their right to access health services. Recommendations to ratify the Convention on the Rights of Persons with Disabilities fall in this category.

Health of LGBTI persons
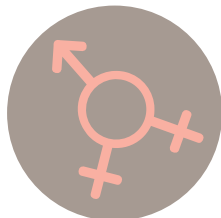
This category includes any issue related to lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons and their right to access health services, including general health services but also specific LGBTI health needs, such as hormone therapy and sex reassignment surgery.

HIV/AIDS and STIs

This category is concerned with any recommendation relating to HIV/ AIDS and sexually transmitted infections (STIs), such as access to healthcare for persons with HIV/AIDS or STIs or prevention of the spread of HIV/AIDS and STIs.

TB, malaria and neglected tropical diseases
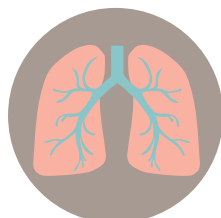
This category includes any health issues related to tuberculosis, malaria or diseases such as rabies, leprosy, foodborne trematodiases, lymphatic filariasis, dracunculiasis (Guinea-worm disease), sleeping sickness, chikunguya, etc.

ANNEX

Vaccinations
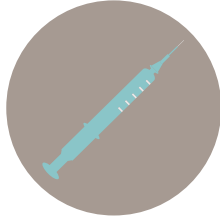
This category refers to any health issues related to immunization, vaccines and pharmaceutical products.

Water and sanitation

This category is concerned with access to safe or clean drinking water and basic standards of sanitation, including drinking-water quality management, water supply and sanitation monitoring, cholera surveillance and prevention, water and sanitation in different settings, and water resources management.
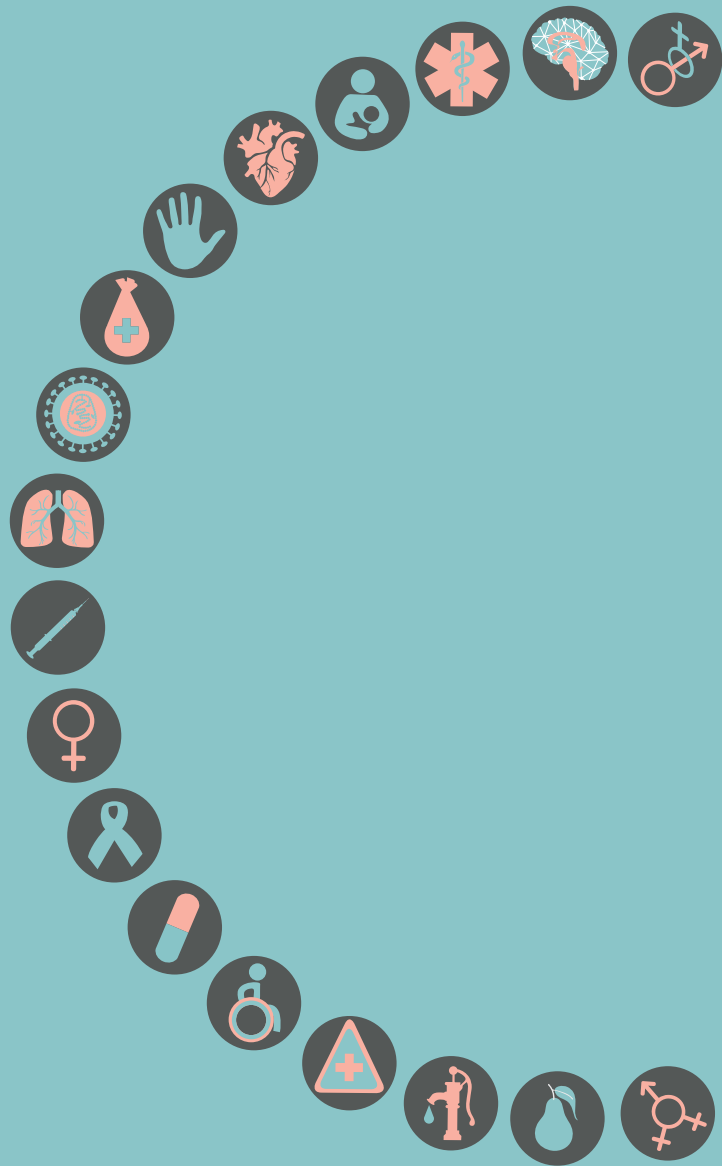
Nutrition

Recommendations relating to food were included when they referred to nutrition or diet-related concerns such as obesity, malnutrition or micronutrient supplementation.

(1) OHCHR, Universal Periodic Review (2019).
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(2) Resolution adopted by the General Assembly, A/RES/60/251, 3 April 2006, p. 9.
At: http://www2.ohchr.org/english/bodies/hrcouncil/docs/A.RES.60.251_En.pdf.

(3) Centre for Economic, Social and Cultural Rights, *Universal Periodic Review: A skewed agenda? Trends analysis of the UPR's coverage of economic, social and cultural rights* (2016).

(4) United Nations Human Rights Council (HRC), 36th Session, Oral statement Item 6, General Debate, 22 September 2017.
At: https://www.upr-info.org/sites/default/files/news/2017_09_25_upr_info_statement_item_6_gd.pdf.

(5) Human Rights Council, 34th Session, Joint Statement Item 8 by the group of Friends on Human Rights and the 2030 Agenda for Sustainable Development.
At: https://www.universal-rights.org/wp-content/uploads/2017/03/HR-SDGs-Cross-reg.-statement.pdf.

(6) UNFPA, *Lessons from the First Cycle of the Universal Periodic Review: From commitment to action on sexual and reproductive health and rights* (2014, New York).

(7) UN General Assembly, Human Rights Council, Resolution adopted by the General Assembly, A/RES/60/251, 3 April 2006. At: http://www2.ohchr.org/english/bodies/hrcouncil/docs/A.RES.60.251_En.pdf.

(8) Human Rights Council, Decision 6/102, Follow-up to Human Rights Council resolution 5/1.
At: http://ap.ohchr.org/documents/E/HRC/decisions/A_HRC_DEC_6_102.pdf.

(9) Universal Rights Group, *Towards the third cycle of the UPR, Stick or Twist?* (2016, Geneva).

(10) Op. cit. 5

(11) Op. cit. 9

(12) Paul Hunt, 'Configuring the UN Human Rights System in the "Era of Implementation": Mainland and Archipelago', *Human Rights Quarterly,* 39' (3), pp. 489-538.

(13) UPR Info, *Beyond promises: the impact of the UPR on the ground* (2014, Geneva).

(14) Report of the Secretary-General on the work of the Organization, A/72/1, 2016, para. 98.
At: https://digitallibrary.un.org/record/1299062/files/A_72_1-EN.pdf.

(15) Report of the Secretary-General on the strengthening of the United Nations action in the field of human rights through the promotion of international cooperation and the importance of non-selectivity, impartiality and objectivity, A/72/351, 21 August 2017.
At http://daccess-ods.un.org/access.nsf/Get?Open&DS=A/72/351&Lang=E .

(16) WHO, *WHO presence in countries, territories and areas* (2018, Geneva).

(17) UPR Info, Database of recommendations. At: https://www.upr-info.org/database/.

(18) WHO News release, 'Violence against women a "global health problem of epidemic proportions"', 20 June, 2013. At: http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/.

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(20) Human Rights Council, 35th Session, Opening Statement by Zeid Ra'ad Al Hussein, United Nations High Commissioner for Human Rights, 'Denial of access and lack of cooperation with UN bodies will not diminish scrutiny of a State's human rights record'.
At: http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=21687&LangID=E.

(21) Human Rights Council, 18th Session, Preventable maternal mortality and morbidity and human rights,
A/HRC/21/22. At: http://daccess-ods.un.org/access.nsf/Get?Open&DS=A/HRC/18/L.8&Lang=E
2011.

(22) WHO, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence* (2013, Geneva).

(23) Op. cit., 3, page 5.

(24) Op. cit., 13, page 5.

(25) Op. cit.,13, page 9.