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Health as an enabler of dignity

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on the right to health as an enabler of human dignity throughout the life course.

The Special Rapporteur explores the intrinsic relationship between dignity and the enjoyment of the right to health. She analyses how dignity operates, both as a foundational principle of the right to health and as a practical condition for its realization.

She examines violations of dignity, including stigma, discrimination, criminalization, coercion, violence and exclusion from decision-making, as root causes of poor health outcomes. She underscores that these factors disproportionately affect persons, groups and communities who have been systematically marginalized.

The Special Rapporteur situates dignity within the normative framework of the right to health and its interdependence with other human rights, including the rights to life, equality and non-discrimination, privacy, information and informed consent, and with access to the underlying determinants of health.

She highlights the role of the underlying determinants of health, including social, legal and commercial determinants of health, in shaping the conditions in which people are born, live, work, age and die, including the harmful effects of punitive legal frameworks and unregulated commercial practices on autonomy, access to care and health equity.

The Special Rapporteur asserts that health cannot be realized without dignity, and dignity cannot flourish without health. She calls upon States and other stakeholders to place dignity at the centre of health legislation, policies and practices by removing structural barriers, strengthening participation and accountability, regulating the power of non-State actors and prioritizing those left furthest behind.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health stresses that dignity is the inherent and equal worth of every human being; it is not conditional on status or achievement, but grounded in the fact of being human, including the shared capacity to suffer, to depend on the empathy of others and to develop one's personality and life plans.[1] She asserts that the human rights system is anchored in this understanding. In 1948, States agreed that all human beings are born free and equal in dignity and rights, establishing a universal baseline for the relationship between the individual, the community and the State.[2]

2. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health derives from this principle. The mandate holder affirms that, through its realization, the right to health reinforces dignity, and she stresses that health and dignity are mutually reinforcing across the life course: dignified treatment supports well-being, and good physical and mental health enables autonomy, participation and flourishing within one's community.

3. Dignity is not a rhetorical add-on to health policy, but rather a normative and practical standard that requires States to treat individuals as rights holders with agency, to distribute resources fairly, to remove structural barriers and to ensure that systems of care recognize diversity and respect self-defined identities.

4. At the start of her tenure, the Special Rapporteur identified dignity as a strategic priority, seeking to treat it as a pivotal principle permeating the right to health.[3] Across her thematic work on sexual and reproductive health rights, harm reduction, racism, digital technologies, food systems, mental health and the rights of health and care workers, the mandate holder has identified recurring indignities, including stigma, discrimination, criminalization, non-consensual treatment, barriers to underlying determinants of health and violence as root causes of avoidable morbidity, mortality and suffering.[4]

5. The Special Rapporteur asserts that vulnerability and dependency are part of the human condition, yet laws and policies often create avoidable, patterned vulnerability by concentrating power asymmetries and exposing some marginalized groups and communities to heightened risks of indignity and negative health outcomes. She highlights that criminalization, discrimination and stigmatization frequently push people to the margins, deepen social exclusion and deny equal access to services, information, participation and accountability.

6. Beyond access to healthcare and the underlying determinants of health, dignity and equity require the meaningful participation of affected groups and communities in the design, implementation and oversight of laws and policies. She stresses that participation is both a right and a dignity-affirming practice that improves policy effectiveness by ensuring that decisions are informed by lived experience.[5]

7. In the context of recent global crises, including pandemics, climate-related disasters, conflict and protracted humanitarian emergencies, the mandate holder considers that rights-based health approaches must meet imminent needs while building resilient, inclusive systems with sustainable communities as an urgent outcome. A dignity lens helps to ensure that emergency responses do not entrench discrimination, coercion or exclusion and that recovery and rebuilding investments strengthen long-term equity. In her analysis, the Special Rapporteur applies an intersectional approach, adopting anti-racist and anti-colonial frameworks, as she has applied throughout her tenure.

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[1] See https://delawarelaw.widener.edu/files/resources/dignityrightssynopsisjuly2017.pdf.

[2] Universal Declaration of Human Rights, preamble and art. 1; and International Covenant on Economic, Social and Cultural Rights, art. 12.

[3] See Human Rights Council resolution 60/10 and A/HRC/47/28.

[4] See A/HRC/56/52.

[5] See A/79/177.

II. Methodology

8. The present report was prepared pursuant to Human Rights Council resolution 60/10 and builds on the mandate holder's prior thematic reports, work undertaken by the mandate holder and on the communications sent to various stakeholders. The Special Rapporteur also drew on submissions received through a public call for input.[6]

9. In the report, the Special Rapporteur has adopted a substantive equality approach and recognized that health inequities are produced through intersecting structures, including racism, sexism, classism, ableism, xenophobia, homophobia and transphobia. She considered both direct and indirect discrimination, as well as structural and de facto discrimination and the cumulative impact of intersecting stigmas.

10. The Special Rapporteur analysed how underlying determinants of health shaped exposure to risks and barriers to care and how dignity-affirming governance, laws, policies and practices could strengthen enjoyment of the right to health and related rights.

11. The Special Rapporteur used a life-course perspective, recognizing that dignity-related threats to health might begin before birth and continue through childhood, adolescence, adulthood and older age, including at the end of life. She also considered how stigma, discrimination and criminalization affected both care-seekers and health and care workers and how those dynamics were interconnected, having a negative impact on the dignity of people.

III. Normative framework and obligations of States

A. Normative framework

12. Articles 2 (2) and 12 of the International Covenant on Economic, Social and Cultural Rights recognize the right to the highest attainable standard of physical and mental health without discrimination. The Committee on Economic, Social and Cultural Rights has underscored that the right to health must be understood as conducive to living a life in dignity.[7]

13. Dignity is a foundational principle across core human rights treaties and regional instruments,[8] as it informs the content of the right to health and frames States' duties to respect, protect and fulfil health in a manner consistent with autonomy, equality and participation.[9]

14. A dignified life requires the realization of other interdependent rights, including the rights to food, housing, safe drinking water and sanitation, work, social security, education, privacy, information, life, access to scientific progress, equality and non-discrimination.[10] Failures in these interconnected rights frequently manifest as barriers to health, compounding indignity.

15. The right to health is grounded in the right to life, which must be interpreted as the right to enjoy a life with dignity. States' duties to protect life extend to reasonably foreseeable threats, including those emanating from private actors, and require action against stigma, violence and harmful practices.[11] The right to health is an inclusive right that includes access to timely and appropriate healthcare, including facilities, goods and services that are available, accessible, acceptable and of quality. It also encompasses the underlying determinants of

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[6] See www.ohchr.org/en/calls-for-input/2026/call-input-health-enabler-dignity-hrc62-report.

[7] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, paras. 1, 8–12, 18 and 33–37.

[8] See A/HRC/WG.11/42/1, para. 10.

[9] Universal Declaration of Human Rights, preamble and art. 1; and International Covenant on Economic, Social and Cultural Rights, art. 12.

[10] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

[11] Human Rights Committee, general comment No. 36 (2018) on the right to life, paras. 3, 18, 21 and 26.

health, such as safe and adequate food, nutrition and housing, safe drinking water and sanitation and health-related education and reliable health-related information.[12]

16. Dignity also requires that individuals are not treated merely as objects of policy but as rights holders and participants in its formation processes. The right to participate in public affairs and in health-related decision-making strengthens the legitimacy and effectiveness of health systems and reduces the risk that policies or practices will reproduce stigma or neglect lived realities.[13] The progressive realization and the principle of non-retrogression of economic, social and cultural rights are also important components of ensuring people's health and dignity, in particular for those pertaining to marginalized groups of the population.[14]

B. Obligations of States

17. States have obligations to respect, protect and fulfil human rights. In the context of the right to health, the duty to respect requires States to refrain from interfering directly or indirectly with the enjoyment of health, including by avoiding adopting legislation, policies or practices that contribute to preventable morbidity and mortality.

18. The duty to respect includes refraining from creating and enforcing discriminatory laws, policies and practices and repealing them where they exist. It also encompasses avoiding coercive practices in healthcare and ensuring that bodily autonomy, informed consent, confidentiality and privacy are protected.

19. The duty to protect requires States to take legislative and other measures to prevent third parties from interfering with the enjoyment of the right to health. This includes regulating health providers, corporate actors and other private entities whose practices may undermine health and dignity, ensuring accountability if the right to health is negatively affected.

20. The duty to fulfil requires States to take deliberate, concrete and targeted steps, to the maximum of available resources, to realize the right to health in a manner consistent with dignity. This includes creating enabling environments, addressing the underlying determinants of health, providing services and reliable information and ensuring effective participation and accountability.

21. While some aspects of the right to health are subject to progressive realization, the Special Rapporteur stresses that the obligations of non-discrimination, equality and providing access to essential services and minimum core protections are of immediate effect. Dignity-based approaches therefore require urgent action where legal frameworks, policies or practices produce exclusion or harm.[15]

IV. Health and dignity as intertwined rights

A. Dimensions of the right to health

22. The right to health encompasses three interrelated dimensions: autonomy, healthcare and prevention. Achieving health with dignity requires advancing all three dimensions together, including through action on the underlying determinants of health and through safeguards that protect agency, equality and non-discrimination.

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[12] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 1, 8–12, 18 and 33–37.

[13] See A/79/177.

[14] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 32 and 48.

[15] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights, paras. 8–10 and 18–27.

23. First, the autonomy dimension includes freedoms and entitlements that protect individuals from interference with bodily autonomy and enable responsible decisions about health and bodies, free from coercion, stigma and discrimination.

24. Second, the healthcare dimension requires a system of facilities, goods and services that are available, accessible, acceptable and of quality, delivered under equitable conditions and responsive to diverse needs with the objective to leave no one behind.

25. Third, the prevention dimension requires measures to prevent the onset and progression of disease and to create conditions that enable all people to live healthy lives, including by addressing the social, legal and commercial determinants of health.

26. Dignity is both a minimum standard – prohibiting violence, coercion and degrading treatment – and a progressive compass, guiding health systems towards substantive equality, inclusion, participation and non-discrimination.

27. To operationalize dignity, States should integrate human rights standards into legislation, health policies and regulations, ensure that budgeting and resource allocation prioritize those left furthest behind and build participatory mechanisms that embed lived experience into design and oversight to ensure accountability.

28. Dignity safeguards a sphere of individual privacy and bodily integrity and autonomy. It requires protection from degrading treatment, intrusive searches or surveillance and violations of bodily autonomy, including in the context of health-related examinations and treatment.[16]

29. Conceptualizing health through dignity recognizes people not merely as patients but as rights holders entitled to respect and agency in decisions about their bodies and health. This includes access to understandable and reliable information, adequate time to decide and the ability to refuse or withdraw treatment without retaliation or fear of retaliation. It requires that consent frameworks are meaningful in practice. This includes reasonable accommodation for persons with disabilities and older persons, accessible communication, and supported decision-making arrangements that respect legal capacity and preferences.[17]

30. In sexual and reproductive health rights, dignity requires respect for decisions about reproduction and sexual life and protection from punitive legal restrictions on bodily autonomy that generate stigma and discrimination. Restrictions that punish abortion seekers, providers or those who assist them can force individuals into unsafe practices and deter them from seeking or providing post-abortion care.[18]

31. The criminalization of same-sex relations and gender diversity undermines dignity by denying intrinsic worth, increasing exposure to violence and deterring access to prevention and treatment services. Dignity-based approaches require the repeal of punitive laws and measures to prevent discriminatory policing and violence.[19]

32. Digital innovation can advance health, equity and inclusion when accompanied by robust privacy, confidentiality and integrity protections. Otherwise, conversely, intrusive data practices and weak confidentiality can lead to the criminalization or stigmatization of individuals and undermine dignified access to care.[20]

33. Autonomy is strengthened when communities can influence underlying determinants of health, including through participatory governance of food systems, environmental policies and health technologies. Dignity-based participation therefore supports both individual agency and collective well-being.[21]

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[16] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) , para. 8; and A/64/272; see also A/64/272.

[17] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law and general comment No. 5 (2017) on living independently and being included in the community.

[18] See A/76/172.

[19] Ibid.

[20] See A/HRC/53/65.

[21] See A/79/177.

B. Autonomy

34. The Special Rapporteur reiterates that bodily autonomy and informed consent are cornerstones of dignity in healthcare.[22] Prior, free and informed consent, supported by accessible and reliable information, is required before any medical treatment, as is respect for privacy and bodily integrity.[23]

35. Access to accurate, timely, accessible and reliable health information is an enabling condition for the realization of the right to health and for meaningful autonomy. Without information, individuals cannot make informed decisions about prevention, treatment or care or participate effectively in health-related policymaking and decisions.[24]

36. Confidentiality in healthcare settings is essential to trust and to care-seeking. Weak confidentiality safeguards expose individuals to stigma, violence and legal repercussions and create systemic barriers for marginalized groups, including people living with HIV, migrants, adolescents, older persons, sex workers and people who use drugs.[25]

37. Limitations on confidentiality must be exceptional, narrowly tailored and accompanied by procedural safeguards to prevent their arbitrary application. Where reporting duties or data-sharing practices deter care-seeking, they may undermine both health outcomes and dignity.

38. Privacy protections must address emerging challenges related to digital health data and information-sharing. Likewise, intrusive data practices can undermine dignity and deter access to care, particularly where data may be used to criminalize or stigmatize health-related decisions or a person’s identity.[26]

39. The Special Rapporteur emphasizes that dignity-based data governance requires robust safeguards for data integrity, security and confidentiality, including protections against surveillance and profiling that disproportionately affect marginalized groups and accessible remedies for the misuse of personal health information.[27]

C. Equality and non-discrimination

40. Equality and non-discrimination are immediate obligations.[28] Discrimination in access to healthcare and underlying determinants of health, as well as to the means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, sexual orientation and civil, political, social or other status has the effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[29]

41. Direct discrimination includes acts or omissions that treat individuals less favourably on prohibited grounds, including race, sex, disability, health status, economic and social situation, sexual orientation and gender identity.

42. Indirect discrimination includes apparently neutral laws, policies or practices that have disproportionate and adverse impact on protected groups, such as documentation requirements that lead to the exclusion of migrants, homeless persons or others from care.

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[22] See A/64/272.

[23] International Covenant on Civil and Political Rights, art. 7; and Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 8.

[24] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (b) (iv) and (c).

[25] Ibid.

[26] See A/HRC/53/65.

[27] Ibid.

[28] International Covenant on Economic, Social and Cultural Rights, art. 2 (2).

[29] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 18.

43. Dignity-based approaches require States to identify and remove both forms of discrimination, including through positive measures that prioritize those left furthest behind. This includes modifying legal frameworks linked to stigma and marginalization and ensuring culturally safe services.[30]

44. Non-discrimination requires attention not only to formal equality but to the lived effects of intersecting forms of oppression. Where individuals experience overlapping stigma – for example, on the grounds of race, sexual orientation, gender identity and health status – barriers to care can be compounded and require tailored, participatory responses.

D. Underlying determinants of health

45. The Special Rapporteur emphasizes that health outcomes are shaped not only by biology and individual behaviour but also by the circumstances and environments in which people are born, live, work, age and die. Dignity therefore demands attention to the underlying determinants of health, beyond healthcare access alone.[31]

46. Social determinants of health – such as income, housing, education, employment, food security and exposure to violence – are shaped by historical and ongoing discrimination, exclusion and stigmatization. Where these conditions are steeped in systemic barriers, they produce preventable health inequities and constrain people from living dignified lives.[32]

47. Stigma operates as a powerful underlying determinant of health by producing social exclusion and discriminatory treatment. The mandate holder reiterates that structural determinants, including racism and other intersecting forms of discrimination, can lead to delayed diagnosis, poor treatment experiences, inadequate pain management and avoidance of services, thereby worsening outcomes.[33]

48. Stigma also undermines mental health. Discriminatory experiences in mental healthcare settings or stigma in society can deter people from seeking help, increase reliance on coercive institutional responses and reinforce social distance and devaluation. Likewise, community-based services and safeguards against coercion are key components of dignity-based mental health policy.

49. Legal determinants of health include laws, policies and practices that entrench stigma and shape access to services. Excessively punitive frameworks that criminalize behaviours, identities or health conditions can create barriers to prevention, diagnosis and treatment and intensify exposure to violence, harassment and arbitrary enforcement.[34]

50. Criminalization can undermine trust in health systems when individuals fear that contact with health providers will lead to punishment, detention, arrest, deportation or loss of child custody. Such fear affects care-seeking for acute conditions, chronic disease management and preventive services.

51. In some contexts, anti-immigration policies, racism or racial profiling restrict access to health services or can lead to unfair reporting obligations for health and care workers, deterring affected individuals from seeking care and forcing a choice between health and safety. The Special Rapporteur warns that mandates for information-sharing with law enforcement can undermine confidentiality and erode the trust that is essential to patient-provider relationships.

52. Commercial determinants of health also threaten dignity. Where harmful products and practices are unregulated or poorly regulated, corporations may aggressively market tobacco, alcohol and unhealthy foods while lobbying against protective policies, exacerbating

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[30] Ibid., paras. 8–10 and 18–27.

[31] See www.who.int/news-room/questions-and-answers/item/determinants-of-health; and www.who.int/health-topics/social-determinants-of-health.

[32] Ibid.

[33] See A/76/172.

[34] See A/HRC/56/52.

inequities and constraining meaningful choice, having a deterrent effect among marginalized groups, including people in situations of poverty and young people.[35]

53. Food and beverage marketing – particularly where misleading or digitally targeted – can undermine autonomy by shaping preferences and exposures through exploitative tactics that prioritize profit over well-being. The Special Rapporteur stresses that dignity-based governance requires addressing conflicts of interest and ensuring that evidence, not corporate influence, drives public health policy.

54. Dignity-based responses also require transforming conditions that create and perpetuate patterns of privilege and oppression, including by removing harmful criminalization, regulating corporate actors, strengthening social protection and ensuring the participation of affected communities in decision-making.

55. In situations of emergency and resource scarcity, discriminatory triage criteria can devalue some lives through quality-of-life judgments or long-term survival predictions linked to disability or age. Dignity requires that clinical criteria avoid discriminatory assumptions and that safeguards ensure equal access to facilities, care, commodities and services.

E. Dignified health delivery and care

56. Dignity requires healthcare that is available, accessible, affordable, of good quality, culturally acceptable and free from discrimination. It also requires systems that are sensitive to diversity and that prevent violence, coercion and stigmatizing treatment.

57. In practice, healthcare can be a space of dehumanization and exclusion. Marginalized communities may experience discrimination, stigmatization and racism within health systems, leading to avoidance of care, worsening health outcomes[36] and abrasive relationships with health and care workers.

58. The Special Rapporteur warns that health systems that disregard self-defined gender identity, neglect Indigenous knowledge or rely on institutionalization for psychosocial disability can undermine dignity by denying agency and belonging. Likewise, dignity-based services require the integration of intercultural and Indigenous knowledge, respectful communication and support for community-based care.

59. Criminalization and punitive policies can further exclude individuals from care. Sex workers may avoid treatment for fear of retaliation or referral to the criminal justice system; people who use drugs may avoid care due to fear of punishment; and abortion-seekers may resort to unsafe practices to avoid detection, delaying care even when complications arise.[37]

60. Dignity-based care requires robust confidentiality and professional secrecy, including to ensure access to treatment for obstetric emergencies and post-abortion care and to prevent immigration enforcement from deterring care-seeking.[38]

61. Palliative care is an essential component of health with dignity across the life course. Strengthening palliative care within health systems alleviates avoidable pain and suffering and supports informed choices about accepting, refusing or withdrawing treatment, including through the provision of culturally appropriate services and clear information.[39]

62. The mandate holder emphasizes that the dignity of health and care workers is integral to health with dignity. Safe working conditions, protection from violence, adequate resourcing and participation in decision-making enable health and care workers to deliver rights-based care and to act as defenders of the right to health.[40]

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[35] See A/78/175.

[36] See A/77/197.

[37] See A/HRC/56/52.

[38] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (b) (iv) and (c).

[39] See www.who.int/health-topics/palliative-care; and World Health Assembly resolution WHA67.19.

[40] See https://iris.who.int/server/api/core/bitstreams/3ef6ee65-42fa-4d2b-9c75-d55b2df17f9a/content.

63. Workforce strategies should include training on human rights, non-discrimination and cultural safety and should address the structural inequities affecting health workers, including racism, gender discrimination and precarious employment conditions.

64. Dignity-based quality of care includes respectful maternity care, the prevention of obstetric violence, safeguards against coercion and neglect and policies that enable informed decision-making throughout the life course.

65. The mandate holder warns that health systems should prepare in advance to avoid discriminatory approaches in situations of emergency and resource scarcity. She notes that protocols and triage guidelines should be designed to respect equal worth and avoid explicit or implicit reliance on protected characteristics such as disability or age.

66. Where services are delivered in culturally inappropriate ways, particularly among Indigenous Peoples and minority communities, dignity-based approaches require adaptation, interpreters where needed and the recognition of community knowledge and preferences.

67. Dignified healthcare is strengthened when services are delivered in community settings, unnecessary institutionalization is reduced and social support services, such as housing, income support and legal aid that address determinants of health and take into account historical marginalization and exclusion, are integrated into the delivery approach.

F. Prevention of harm: creation of enabling environments

68. Preventive health policies are dignity-based when they expand meaningful choice rather than constrain it.

69. The right to health contains both freedoms and entitlements. Freedoms include the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements under the right to health include the right to a system of health protection (i.e. healthcare and the underlying social determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

70. Dignity demands the equitable distribution of the underlying determinants of health, including access to adequate nutritious food, education and social protection, as well as accessible and reliable information. The prevention of harm requires addressing conditions that make people sick and promoting conditions that make health attainable.

71. The climate crisis also has a negative impact on human dignity and security. Its human and environmental impact includes loss of land and housing, diminished quantity and quality of food production, food insecurity and malnutrition and forced displacement.

72. Food systems shaped by globalization and powerful corporate interests can displace healthier traditional diets and increase exposure to unhealthy, ultra-processed foods through aggressive and sometimes misleading marketing. In this regard, digital targeting can intensify exposure for those who are already disadvantaged.[41]

73. The prevention of harm further requires tackling structural racism and other forms of discrimination that shape a person’s exposure to harm, such as air and water pollution, including land dispossession, unsafe working conditions and unequal access to nutritious food and safe housing.

74. She reiterates that harm reduction approaches are essential, where punitive frameworks increase health harm. Measures such as needle and syringe exchange programmes, opioid agonist therapy, drug checking, overdose prevention and social support can reduce preventable morbidity and mortality and uphold dignity.[42]

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[41] See A/HRC/26/31.

[42] See A/HRC/56/52.

75. The Special Rapporteur underscores that the full realization of prevention also depends on strengthening social protection systems, including income support, disability benefits, access to childcare and paid leave, which can reduce health risks and support dignified living.

76. The mandate holder stresses that monitoring and evaluation frameworks should track the equity impact of preventive policies, including the differential impact across race, gender, disability, age and socioeconomic status, and ensure corrective action where disparities persist.

77. The Special Rapporteur emphasizes that preventive policies should integrate environmental determinants of health, including air pollution, water quality and climate resilience, recognizing their impact on health and on the ability to live with dignity. In this regard, prevention requires investment in primary healthcare and community health systems as the foundation for early intervention, continuity of care and building trust.

V. Governance

78. Beyond individual laws and policies, governance structures regulate multisectoral systems affecting health and dignity. Dignity must be embedded within governance through rules, processes and institutions that manage relationships between the State, the private sector, civil society, communities and individuals.[43]

A. Participation

79. Meaningful participation of those most affected by laws and policies in their formulation, implementation and evaluation improves effectiveness and affirms dignity by valuing lived experience. Participation is therefore both an intrinsic right and an instrumental requirement for effective health policy.

80. Criminalization, discrimination and stigma can lead to the exclusion of marginalized groups from policymaking and perpetuate ineffective and harmful policies. The Special Rapporteur notes that removing these barriers is necessary to ensure inclusive participation and to strengthen substantive equality.[44]

81. Participation requires access to reliable information and materials in accessible formats and appropriate languages. In the context of attacks grounded in misinformation, the Special Rapporteur emphasizes that ensuring reliable health information is necessary for autonomy, participation and trust.

82. Participation also requires safety. For communities affected by racial profiling, punitive policing, discrimination or violence, safe participation may require legal protections, confidentiality, resourcing for community organizations and non-retaliation guarantees.

83. The mandate holder notes that participation should occur throughout the policy cycle, including agenda-setting, drafting, implementation and evaluation, rather than being limited to consultation after key decisions have been made.

84. Capacity-building can support meaningful participation, including by ensuring access to technical information, translation and interpretation and by resourcing community-led data collection and monitoring.

85. The mandate holder stresses the importance of health and care workers also participating in policymaking, as their involvement can foster equitable, practical and sustainable policies and improve implementation by grounding decisions in front-line experience.[45]

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[43] See A/79/177.

[44] Ibid.

[45] See https://iris.who.int/server/api/core/bitstreams/3ef6ee65-42fa-4d2b-9c75-d55b2df17f9a/content.

86. She notes that participation is strengthened when States protect civic space and freedoms of association, expression and assembly, recognizing that these freedoms enable advocacy for health and dignity.

87. In humanitarian contexts, participation must include displaced persons, migrants and affected communities in the planning of health services and resource allocation, ensuring that emergency responses do not entrench exclusion.

88. Meaningful participation also requires addressing power asymmetries in global health governance, including ensuring that low- and middle-income countries and affected communities have influence over priorities and financing.

89. The Special Rapporteur stresses that there is a need to count on participation mechanisms that are evaluated for effectiveness and inclusivity, including whether they lead to concrete policy change and whether marginalized voices are genuinely reflected.

90. Participation is also essential in the governance of digital health technologies, including through community input into design, data governance and accountability mechanisms.

91. Participation should be understood as a continuous-cycle practice of dignity in public life, rather than a one-time procedural step, and should involve all interested rights holders.

B. Transparency and conflicts of interest

92. The Special Rapporteur warns that conflicts of interest in governance undermine dignity by displacing public needs with private gain and eroding trust. States’ obligations to respect and protect the right to health include refraining from partnerships that allow decision-making to be co-opted by private interests and preventing third parties from interfering with the realization of human rights.[46]

93. Transparency and access to information are essential to participation and to addressing conflicts of interest, including where corporate actors fund misleading evidence or “washing” practices that distort public understanding of health risks and policy options.[47]

94. In the health sector, transparency is necessary to preserve trust, including transparency in procurement, the allocation of scarce resources and the basis for clinical guidelines.

95. The Special Rapporteur notes the importance of ensuring that complaint mechanisms are accessible to marginalized groups and that remedies include both individual redress and structural reforms.

96. Independent national human rights institutions, ombudspersons and courts can play a role in providing remedies and ensuring systemic accountability, including through the monitoring of health policies and practices.

C. Accountability

97. Accountability requires effective remedies and reparations for rights violations and measures to prevent recurrence through monitoring, regulation and sanctions where appropriate.

98. In health settings, accountability includes systems to report and address mistreatment, discrimination and violence, including obstetric violence and abuses in institutional settings. Training and awareness-raising campaigns can support prevention and the identification of violations.

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[46] See A/79/177.

[47] Ibid.

99. Accountability also requires protection of confidentiality so that individuals can gain access to care without fear of punishment. Standards emphasizing professional secrecy and confidentiality can be critical to ensuring access to emergency care and preventing deterrence from care-seeking.[48]

100. The Special Rapporteur notes that accountability for corporate actors should include regulatory enforcement, penalties for misleading marketing and measures to prevent harm from products and practices that undermine health.

101. In digital health, accountability requires the auditability of systems, impact assessments, safeguards against bias and discrimination and clear pathways for individuals to challenge the misuse of data or automated decision-making.[49]

102. Accountability frameworks should include the participation of affected communities in oversight, ensuring that monitoring reflects lived experience and that remedies respond to harm experienced by marginalized groups.

103. In emergencies, accountability is essential to ensure that exceptional measures are time-bound, proportionate and non-discriminatory and that affected individuals have access to remedies for harm.

104. The mandate holder stresses the importance of international cooperation to address cross-border determinants of health, including corporate practices and global supply chains, ensuring accountability beyond national boundaries.

105. Accountability mechanisms should be periodically reviewed and strengthened, including to incorporate emerging risks from new technologies and evolving commercial strategies. Accountability should also be linked to learning and improvement, using findings to reform policies, strengthen services and prevent future rights violations.

106. In implementing these measures, accountability should not become punitive or stigmatizing in itself, but focus should remain on prevention, remedy and structural change.

VI. Good practices

107. States and stakeholders have reported practices aimed at advancing health and dignity for populations affected by stigma and exclusion. These examples illustrate the practical value of rights-based approaches and the importance of community leadership.

108. In Australia, actions that target the needs of Aboriginal and Torres Strait Islander people recognize the significant existing health disparities and treatment inequities existing in the health system.[50] The authorities are working with both national and local governments to reduce stigma and discrimination associated with mental health and faced by lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender-diverse persons or persons living with HIV, among others.[51]

109. In the Plurinational State of Bolivia, the plurinational plan of mental health (2026–2030) addresses the stigmatization of persons with a mental disorder or with substance use disorder, stressing that domestic legislation requires the care in community centres where the patient does not lose their social connections or autonomy.[52]

110. In Cuba, a national plan on sexually transmitted infections, HIV and hepatitis and associated actions for the period 2019–2023 incorporated a focus on stigma reduction, including interventions at the primary care level and work with key populations.[53]

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[48] Inter-American Court of Human Rights, *Manuela et al. v. El Salvador*, Judgment, 2 November 2021, paras. 204–215.

[49] See A/HRC/53/65.

[50] Submission from Australia.

[51] Ibid.

[52] Submission from the Plurinational State of Bolivia.

[53] Submission from 4Métrica and Civil Rights Defenders (Cuba).

111. In the Dominican Republic, legislation and national plans aimed at eliminating or reducing stigma, discrimination and criminalization, in particular related to HIV, was adopted.[54]

112. In Mexico, the Social Security Institute for Well-being, through its institutional programme for 2025–2030, prioritizes reducing the lack of access to healthcare through a community and intercultural approach, among others.[55]

113. In Morocco, the framework law No. 06-22 relating to the national health system, places respect and human dignity at the heart of care. The law enshrines the protection of the physical and moral integrity of people, the respect of the patient to access to information relating to their health status, as well as the fight against any form of discrimination or stigmatization on the basis of their health status or disability, among other things.[56]

114. In Portugal, HIV/AIDS initiatives have been adopted to address stigma and barriers to healthcare by affected people, including through the establishment of the Anti-Discrimination Centre for HIV and AIDS that provides counselling and legal support to persons living with HIV who experience discrimination or violations of their rights.[57]

115. In Spain, human dignity is placed at the centre of the health system through domestic legislation, which is complemented by policies aimed at eliminating stigma and inequality affecting specific groups. Various plans aimed at reducing structural discrimination, including on harm reduction, mental health and persons affected by HIV, have been adopted.[58]

116. In Türkiye, a road map for HIV/AIDS-related efforts for the period 2025–2030 includes among its objectives the prevention of discrimination against people living with HIV and of violations of confidentiality, with awareness-raising activities.[59]

117. At the regional level, the European Court of Human Rights issued judgments in relation to legal gender recognition procedures that were in violation of the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) and issued jurisprudence referring to trans-specific healthcare, including for persons deprived of their liberty. Furthermore, a body of the Council of Europe working in the rights of intersex persons supports the model that autonomy is a key aspect related to medical procedures.[60]

118. Community-led models of care have sought to redesign services around relationship-based and culturally grounded approaches, including approaches that treat service users as “owners” of or partners in care, reversing paternalistic dynamics.

119. In Spain, Law No. 8/2021 reforming civil and procedural law for the support of persons with disabilities in the exercise of their legal capacity, has the objective of reducing paternalistic practices in the health sector and creating support for persons with disabilities to exercise their autonomy.[61]

120. At the regional level, in 14 countries in Eastern Europe and Central Asia, a community-based mechanism has been established to monitor and respond to stigma and discrimination, major structural barriers limiting access to services for marginalized and key populations.[62]

121. Some States reported strategies to reduce stigma and discrimination in health services through training, professional standards and complaint mechanisms addressing racism and discriminatory treatment.

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[54] Submission from the Dominican Republic.
[55] Submission from Mexico.
[56] Submission from Morocco.
[57] Submission from Portugal.
[58] Submission from Spain.
[59] Submission from Türkiye.
[60] Submission from the Council of Europe.
[61] Submission from Spain.
[62] Submission from the Alliance for Public Health (Ukraine).

122. In Australia, the policy direction to the Health Practitioner Regulation Agency and National Boards is aimed at improving health practitioner’s responses to racism and discrimination; health practitioners are requested to undertake education and training to help to promote a culture of combating racism in healthcare.[63]

123. In the Plurinational State of Bolivia, the Health user Ombudsman, independently investigates complaints of discrimination of verbal abuse, applying administrative sanctions.[64]

124. In Czechia, anonymous, free HIV testing with counselling, educational intervention activities on sexual health and access to pre-exposure prophylaxis for people under 26 years of age and in high-risk groups is used as a prevention measure to reduce HIV transmission.[65]

125. In the Dominican Republic, the National Council for HIV/AIDS monitors and provides support to victims in cases of violations of the rights of people with HIV/AIDS, in coordination with the Human Rights Observatory.[66]

126. In El Salvador, training for healthcare workers is focused on human rights, the humanization of care and the care of populations in situations of vulnerability. In addition, the adoption and implementation of the protocol for the humanization of care within the service network of the Ministry of Health is complemented by a national plan focusing on dignified treatment.[67]

127. In Luxembourg, non-punitive approaches to health-related behaviours and stigma reduction have been taken, in particular related to harm reduction and the decriminalization of sex work, and reforms in mental health care to address stigma and campaigns to combat stigma surrounding HIV/AIDS have been undertaken. The 2014 Law on patients’ rights is aimed at ensuring dignity, informed consent and equal access and mediation in cases of conflict. To address stigma and discrimination affecting marginalized groups, Luxembourg put in place measures, including training for healthcare providers on cultural competency, anti-bias, respectful care for lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender-diverse persons and trauma-informed practice, among other things, accountability and complaint mechanisms, ensuring community engagement and peer involvement, and service adaptations for marginalized groups.[68]

128. In Mexico, the mandatory training for healthcare workers under the Social Security Institute for Well-being is focused on human rights and ensuring a gender perspective, interculturality and dignified treatment. In relation to complaint mechanisms, the National Commission for Medical Dispute Resolution receives complaints and facilitates conciliation and dispute resolution.[69]

129. Several States reported legal reforms or policies strengthening autonomy in healthcare, including measures to protect informed consent, regulate confidentiality and support community-based mental healthcare and deinstitutionalization.[70]

130. In the Plurinational State of Bolivia, regulations are aimed at ensuring that marginalized groups actively participate in the oversight of the health system. In addition, the 2026 Law on the decentralization of health resources allows for local communities to manage funds for preventive health. Furthermore, the Ministry of Health and Sports requests that health personnel ensure that the patient understands their treatment in their own language and within their value system. In addition, through the programme on culturally appropriate

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[63] Submission from Australia.

[64] Submission from the Plurinational State of Bolivia.

[65] Submission from Czechia.

[66] Submission from the Dominican Republic.

[67] Submission from El Salvador.

[68] Submission from Luxembourg.

[69] Submission from Mexico.

[70] See also Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) and general comment No. 5 (2017).

childbirth, tertiary-level hospitals have rooms where a pregnant woman can choose the position for delivery and be accompanied by traditional midwives.[71]

131. In Bosnia and Herzegovina the Law on the prohibition of discrimination, prohibits discrimination on the grounds of health status, disability, gender and other personal characteristics. The Government informed the Special Rapporteur about harm reduction programmes established for people who use drugs, the inclusion of training on patients' rights and a public awareness-raising campaign with the objective of destigmatizing mental disorders. At the entity level, laws on patients' rights and regulations are aimed at guaranteeing the right to informed consent, the right to privacy and confidentiality of health data and the right to refuse medical treatment, while special attention is given to the protection of children, persons with disabilities and persons placed in health and social care institutions, with the objective of reducing power imbalances between service users and healthcare providers.[72]

132. In El Salvador, a national strategy is being developed on HIV aimed at ensuring testing with confidentiality and respectful attention free from stigma.[73]

133. In Luxembourg, the national legal framework, including the Law on patients' rights and the implementation of public health strategies, seeks to address discrimination, ensure dignified treatment and guarantee informed consent, access to medical files, the choice of a provider and the right to refuse treatment.[74]

134. In Mexico, the General Health Law was amended in January 2026 to incorporate digital health, the regulation of the exchange of information and the protection of private data.[75]

135. In Morocco, the collection, management and conservation of personal data are regulated, in particular in relation to confidentiality, finality and security. This framework is aimed at preventing the abusive use of medical information, reducing the risks of stigmatization and restoring patients' confidence in the healthcare system.[76]

136. Norway, launched policy guidance in 2024 on the prevention of substance use, harm reduction and treatment highlighting the right of people with substance use disorders to dignity and serving as overall guidance on the strategy for domestic policy on psychoactive substances. The national professional guidelines for the prevention of coercion in mental healthcare for adults are focused on reducing coercion through improved collaboration between municipal services and specialized healthcare, strengthening early intervention to avoid involuntary admission and enhancing treatment approaches with an emphasis on the patient's involvement and education, among other things.[77]

137. In Spain, accessible community-based services and alternatives to hospitalization are promoted, addressing the social determinants of health. In relation to mental health, a national action plan promotes initiatives that are alternatives to hospitalization and that reduce coercive practices, as well as the development of community programmes centred on the mental well-being of vulnerable groups, among other things.[78]

138. Illustrative measures include patient charters that operationalize dignity through the rights to information, consent, privacy and access to medical records and protocols promoting non-discriminatory access to care for marginalized groups.

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[71] Submission from the Plurinational State of Bolivia.
[72] Submission from Bosnia and Herzegovina.
[73] Submission from El Salvador.
[74] Submission from Luxembourg.
[75] Submission from Mexico.
[76] Submission from Morocco.
[77] Submission from Norway.
[78] Submission from Spain.

139. In Luxembourg, the domestic legislation allows for patients to control which professionals can access which parts of their health data, strengthening trust and personal agency.[79]

140. Several States reported measures to ensure access to gender-affirming care and to remove the pathologization of gender diversity, alongside efforts to prevent harmful so-called “conversion” practices.

141. In Australia, the National Health and Medical Research Council was tasked with developing new national clinical practice guidelines for the care of trans and gender-diverse persons under 18 years of age with gender dysphoria.[80]

142. In the Plurinational State of Bolivia, the national protocol of comprehensive care for gender-diverse persons, rather than having a pathologizing approach, is focused on comprehensive health support and access to hormone replacement therapies under medical supervision free of charge.[81]

143. In Luxembourg, legal, policy and service level steps have been taken with the objective of improving the health and dignity of gender-diverse persons.[82]

144. In Mexico, a protocol for non-discriminatory access to the provision of health-care services for lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender diverse persons promotes the respect to self-declared gender identity. Another specific protocol promotes the training of personnel, the updating of clinical records to respect gender identity and comprehensive sexual, reproductive and mental healthcare.[83]

145. In Norway, people over 16 years of age who want to change their gender are no longer required to undergo medical treatment, and anyone has the right to change their gender based on their own experience.[84]

146. In Portugal, legislative measures have been adopted to address stigma, discrimination and harmful practices related to sexual orientation and gender identity, notably amendment of legislation to ban so-called “conversion practices” and criminalize acts intended to alter, limit or repress a person’s sexual orientation, gender identity or gender expression. The amendment includes provisions for such measures as awareness-raising campaigns targeting parents, families and communities on the ineffectiveness and harmful consequences of conversion practices.[85]

147. In Spain, Law No. 4/2023 is aimed at ensuring access without discrimination to health services and eliminating the pathologization of diverse gender identities; since 2025, care for transgender or gender-diverse persons has been included in the catalogue of procedures requiring a specialist’s attention at centres, services and referral units.[86]

148. Other measures include strategies to expand health insurance coverage for people living with HIV, stigma-reduction campaigns targeting the attitudes of health workers and differentiated, user-centred services.

149. In the Dominican Republic, an inter-institutional social protection strategy enabled the inclusion of 34,000 people living with HIV in the subsidized regime of the National Health Insurance as of December 2025.[87]

150. Digital approaches have been used to expand access, while protecting privacy, including the confidential ordering of HIV self-test kits and optional linkage to prevention and treatment services.

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[79] Submission from Luxembourg.
[80] Submission from Australia.
[81] Submission from the Plurinational State of Bolivia.
[82] Submission from Luxembourg.
[83] Submission from Mexico.
[84] Submission from Norway.
[85] Submission from Portugal.
[86] Submission from Spain.
[87] Submission from Dominican Republic.

151. Some States reported policies regulating conscientious objection in reproductive health services to prevent denial of access, alongside legal reforms clarifying service provision responsibilities.

152. In Spain, the regulation of conscientious objection and the creation of a registry of objecting professionals constitutes important instruments that is aimed at avoiding the scenario wherein collective objection limits the right to abortion.[88]

153. Initiatives reported to the Special Rapporteur also included mobile health services to reach rural and remote communities and legal frameworks to regulate digital health services and information systems.

154. In Bosnia and Herzegovina, the development of mobile and outreach health services, particularly in rural and remote areas, as well as the training of healthcare professionals to work with marginalized and vulnerable groups, among other things, is aimed at addressing and eliminating stigma and discrimination.[89]

155. In El Salvador, the incorporation of mental health units at the level of primary health care, with the inclusion of virtual consultations for psychotherapy through an online platform, is a way to contribute to reducing geographical barriers.[90]

156. These examples underscore that dignity can be operationalized through legal protections, community leadership and governance reforms that shift power towards affected communities and rights holders.

157. Some States informed the Special Rapporteur about measures to meaningfully include and consult marginalized communities in the design, implementation and evaluation of health policies and programmes affecting them.

158. Australia informed the Special Rapporteur that the third edition of the National Safety and Quality Health Service Standards was being developed in consultation with Aboriginal and Torres Strait Islander Peoples, persons with intellectual disabilities and members of their families and their carers, persons who have been culturally or racially marginalized and people living in rural and remote areas. Other initiatives illustrate the efforts to undertake consultations with other stakeholders, including women’s groups, lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender-diverse organizations, disability rights advocates, people with lived experience of mental health challenges and/or suicidality and members of their families.[91]

159. The Plurinational State of Bolivia indicated that, through the Social Councils of Health, representatives of sex workers, migrants, persons living with HIV and Indigenous Peoples evaluate the fulfilment of the health goals in their respective regions, ensuring that the programmes are adjusted to their specific needs.[92]

160. The Dominican Republic and El Salvador informed the Special Rapporteur that marginalized communities, in particular HIV-affected populations, were included in the development of national plans or strategies.[93]

161. Mexico indicated that the National Council to Prevent Discrimination promoted the active participation of communities, through spaces of dialogue and consultations with civil society organizations and elaborated recommendations based on the obtained information, through complaint mechanisms, studies, diagnostics and testimonies. The Council also developed strategies of direct community participation.[94]

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[88] Submission from Spain.

[89] Submission from Bosnia and Herzegovina.

[90] Submission from El Salvador.

[91] Submission from Australia.

[92] Submission from the Plurinational State of Bolivia.

[93] Submissions from the Dominican Republic and El Salvador.

[94] Submission from Mexico.

162. Examples of how equitable access to health education and information is aimed at reducing inequalities and strengthening the health system have also been shared with the Special Rapporteur.

163. In Australia, an initiative to provide information on vaccine development, safety and effectiveness and to address community concerns related to coronavirus disease (COVID-19) vaccination was adopted.[95]

164. In Luxembourg, marginalized communities are increasingly included in the design, implementation and evaluation of health policies, mainly through consultations with civil society.[96] Schools also provide comprehensive, age-appropriate education on nutrition, mental health, sexual and reproductive health and substance use prevention.[97]

165. In Mexico, the promotion of policies and programmes to ensure access to health education and information, with a focus on equality and the strengthening of the health system, including for rural communities and marginalized groups in urban communities, is aimed at filling gaps.[98]

166. Spain informed the Special Rapporteur that patients' empowerment was promoted though the Network of Health Schools for Citizens, which integrates health schools in all the autonomous communities in the country. In relation to sexual health and HIV, the Government indicated that campaigns and specific material improved health knowledge among vulnerable groups.[99]

167. In relation to examples to address conflicts of interest, some States informed the Special Rapporteur about measures taken.

168. The Plurinational State of Bolivia informed the Special Rapporteur that, in 2026, the Ministry of Health and Sports had implemented a referral traceability system aimed at preventing public sector physicians from diverting patients to private clinics under their control, with the purpose of ensuring that medical decisions were based exclusively on the patient's well-being and not on personal financial gain.[100]

169. El Salvador applied the Public Procurement Law and government ethics regulations that prevented undue influence by the pharmaceutical industry on medical prescribing, ensuring that clinical decisions were based solely on the best available evidence and on respect for patient dignity, above commercial interests.[101]

170. Luxembourg informed the Special Rapporteur that, to mitigate financial incentives influencing clinical decisions, the Government had regulated fee schedules, put in place ethical rules requiring doctors to prioritize the patient's interests and a mandatory declaration of financial interests and had the National Health Service monitor unusual prescribing patterns.[102]

171. Mexico informed the Special Rapporteur about progress made in the implementation of regulatory frameworks, bioethics committees, asset and interest disclosure obligations and oversight mechanisms aimed at ensuring that health-related decisions were made on the basis of the public interest, equity and the unrestricted respect for human dignity.[103]

172. Spain indicated the promotion of community-based care models, strategies for reducing medication use and social prescribing, while reducing incentives for overprescribing and reinforcing non-pharmacological and community-based options.[104]

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[95] Submission from Australia.

[96] Submission from Luxembourg.

[97] Ibid.

[98] Submission from Mexico.

[99] Submission from Spain.

[100] Submission from the Plurinational State of Bolivia.

[101] Submission from El Salvador.

[102] Submission from Luxembourg.

[103] Submission from Mexico.

[104] Submission from Spain.

VII. Current challenges

173. Although there are initiatives aimed at addressing stigma and discrimination, people with intellectual and developmental disabilities and persons with Down Syndrome reportedly continue to face systemic barriers to access to appropriate, continuous and respectful care.[105] While there is a normative framework, policies and other initiatives in place to address discrimination based on HIV status and to ensure a strict regime of confidentiality of medical information, in practice, respect of confidentiality and negative behaviours from service providers were reportedly challenges that still need to be addressed.[106]

174. While health disparities are being addressed in several countries, Indigenous Peoples reportedly experience persistent health outcome disparities because of structural or systemic discrimination.[107] In several countries, marginalized groups are reportedly not formally included in consultation processes or the design of health policies,[108] and people deprived of their liberty have limited opportunities to participate in domestic health planning, monitoring or policy development.[109]

175. While initiatives to address stigma and discrimination faced by gender-diverse persons are being taken, in some countries, the reported lack of legislation prohibiting unnecessary surgery or treatment for intersex persons or persons with variations in sex characteristics, or ensuring their right to bodily autonomy, can result in stigma, in addition to encouraging irreversible medical interventions without the rights holders' consent.[110]

176. Furthermore, existing laws and policies can serve as a barrier to the adoption and implementation of rights-based policies for marginalized populations; accompanied by a lack of effective accountability mechanisms, conflicts of interest can play a central role to further undermine the dignity of persons deprived of their liberty.[111]

177. The digitalization of healthcare has the potential to enhance health outcomes by tackling unequal access to healthcare services, the related access costs and patients' ability to access their medical records, prescriptions and medical information, as long as the domestic legislative framework related to digital health is in place and the protection of patients' health data is fully respected.[112]

VIII. Conclusions and recommendations

178. **Health cannot be realized without dignity, and dignity cannot flourish without health. A rights-based approach centred on dignity is therefore necessary to respond to urgent health needs while fostering resilient and sustainable communities.**

179. **Accountability is a communal expression that violations of dignity will not be tolerated. Effective accountability therefore strengthens social trust and reinforces the normative force of the right to health.**

180. **States should respect, protect and fulfil the right to health in a manner consistent with dignity, autonomy, equality, participation and accountability, including by addressing social, legal and commercial determinants of health.**

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[105] Submission from Jerome Lejeune Foundation.

[106] Submission from Avocats sans frontières Canada and the Association des juristes sénégalaises.

[107] Submissions from the Assembly of Manitoba Chiefs and from Diamond Johnny.

[108] Submissions from the Association of People with Disability (Bangalore) and from the Faculdade de Medicina da Universidade de São Paulo and Associação dos Jovens Indígenas (Brazil) and from Amnesty International.

[109] Submission from Eurasian Movement for the Right to Health in Prisons.

[110] Submissions from Beyond the Boundary – Knowing and Concerns Intersex, from Brújula Intersexual (Mexico and Latin America) and from the Center for Reproductive Rights, Women Enabled International, the International Planned Parenthood Federation and ILGA World.

[111] Submission from Physicians for Human Rights Israel.

[112] Submission from the Digital Health and Rights Project.

181. **The Special Rapporteur recommends that States and other relevant stakeholders:**

(a) **Adopt legal frameworks that guarantee confidentiality, privacy and informed consent, with safeguards for communities at heightened risk of stigma or criminalization, and ensure accessible and reliable health information;**[113]

(b) **Repeal punitive frameworks that criminalize health-related behaviours, identities or conditions and that create barriers to care and adopt harm reduction measures to mitigate harm and protect access to services;**[114]

(c) **Regulate the conduct of non-State actors, including corporations, that undermines health, including harmful marketing practices, misinformation and conflicts of interest, and ensure transparency and accountability in decision-making;**[115]

(d) **Consider restrictions or bans on the marketing of unhealthy foods, tobacco and alcohol and the implementation of front-of-package warning labels, fiscal measures that disincentivize harmful products and rules for healthy procurement in public institutions, consistent with evidence and human rights principles for businesses;**

(e) **Ensure that health services, including mental health services, are available, accessible, acceptable and of high quality for historically marginalized populations, including through culturally safe care and community-based services;**

(f) **Invest in health literacy and community education, including through digital platforms with safeguards against misinformation, ensuring that information is accessible, culturally appropriate and free from conflicts of interest;**[116]

(g) **Protect the dignity and rights of health and care workers, including through safe working conditions and participation in policymaking and include a focus on human rights in medical education and training;**[117]

(h) **Ensure mechanisms for transparency and meaningful participation in decision-making spaces among communities whose health and well-being are affected by those decisions, including those that have been historically excluded and marginalized;**

(i) **Create and strengthen accountability mechanisms that prevent, mitigate and provide redress for health- and dignity-related violations by State and non-State actors, including in healthcare settings and in the governance of private power;**

(j) **Prioritize those left the furthest behind in implementing these recommendations and adopt an intersectional approach that addresses compounding forms of discrimination, including for those who have been stigmatized, discriminated against or criminalized based on race, sex, disability, health status, economic and social situation, sexual orientation and gender identity;**

(k) **Ensure that health services, goods and facilities and the underlying determinants of health are accessible without discrimination and based on substantive equality;**[118]

(l) **Support training, curriculum updates and professional standards that address discrimination and implicit bias in health and clinical settings and ensure that complaint mechanisms are accessible and capable of delivering effective remedies;**

(m) **Strengthen the conditions for dignified living by guaranteeing access to adequate housing, food and water, safe working conditions, social protection and**

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[113] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (b) (iv) and (c).

[114] See A/HRC/56/52.

[115] See A/78/175.

[116] See A/79/177.

[117] See https://iris.who.int/server/api/core/bitstreams/3ef6ee65-42fa-4d2b-9c75-d55b2df17f9a/content.

[118] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), paras. 8–10 and 18–27.

education and ensuring that health services are culturally safe and accessible to those most affected by structural disadvantage;[119]

(n) **Integrate palliative care and the principle of dignity in old age into health systems and policies, train health workers, ensure autonomy and relief from avoidable suffering, including through the availability of essential medicines for pain relief, and address barriers to access, including stigma around end-of-life care;**[120]

(o) **Ensure that health financing and governance, including for example procurement policies, reflect the principles of good stewardship and substantive equality, including through targeted outreach, the removal of administrative barriers and ensuring affordability for low-income populations;**

(p) **Where access to safe abortion is restricted, adopt measures to achieve legislative and legal reforms to move towards decriminalization and immediately mitigate harm, including by ensuring access to information and sexual and reproductive health education, affordable contraception, non-stigmatizing care and strict confidentiality protections for post-abortion and emergency care;**[121]

(q) **Where punitive laws remain, adopt measures to reduce discriminatory policing, prevent violence and ensure non-discriminatory access to health services, including HIV prevention and treatment;**[122]

(r) **Include mental health promotion in preventive strategies, recognizing that stigma and exclusion contribute to distress and that community-based services can improve outcomes;**

(s) **Ensure that prevention policies do not become vehicles for coercion, punitive surveillance or discrimination and that any restriction on rights meets the strict necessity and proportionality requirements;**

(t) **Support research and data collection that is ethical, participatory and rights-based, while ensuring strong privacy protections and avoiding stigmatizing data practices;**

(u) **Ensure that participation is inclusive of women, adolescents, older persons, persons with disabilities, lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender-diverse persons, people who use drugs, sex workers, migrants and racialized communities, among others;**

(v) **Establish clear rules on the disclosure of interests, lobbying, revolving-door practices and the funding of research and advocacy, ensure the independent oversight of compliance;**

(w) **Ensure equity in funding for rare diseases, gynaecological advancements and clinical research for neglected conditions;**

(x) **Respect identity, dignity, integrity, autonomy and well-being and uphold non-discrimination, equality, privacy and confidentiality;**

(y) **Repeal punitive frameworks and align domestic policies with public health, human rights and harm reduction; decriminalization is necessary for the right to health to be realized;**

(z) **Ensure that health services are available, accessible, acceptable and of high quality for marginalized populations;**

(aa) **Establish formal participation mechanisms in health governance, including advisory bodies, community oversight structures and participatory budgeting, where appropriate, and ensure the representation of marginalized groups;**

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[119] See A/78/175.

[120] See www.who.int/health-topics/palliative-care; and World Health Assembly resolution WHA67.19.

[121] See A/76/172.

[122] Ibid.

(ab) **Ensure that accountability mechanisms are resourced and that data used for monitoring are disaggregated appropriately to reveal inequities, while maintaining robust privacy protections;**

(ac) **In striving towards realizing the right to health for all, take approaches that take the plurality of human experiences into account, and employ solutions aimed at achieving equality that must take into account the historical and ongoing injustices that necessitate the common commitment to equity;**

(ad) **Protect reliable information and combat misinformation;**

(ae) **Prevent and manage conflicts of interest;**

(af) **Regulate private actors and restrict harmful marketing;**

(ag) **Ensure robust participation;**

(ah) **Establish effective accountability and remedies.**[123]

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[123] See A/79/177.