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## Utilizing Social Epidemiological Profiles in Health and Human Rights Assessments to Advance Public Health

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UTILIZING SOCIAL EPIDEMIOLOGICAL PROFILES IN HEALTH  
AND HUMAN RIGHTS ASSESSMENTS TO  
ADVANCE PUBLIC HEALTH

Dhrubajyoti Bhattacharya, J.D., M.P.H., LL.M.\*

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**Introduction**

Traditional health and human rights assessments do not adequately advance public health. Popular frameworks espoused by scholars and practitioners, though well intentioned, narrowly focus on human rights concerns as a product of downstream risk factors and health outcomes. This approach particularizes the problem within an affected person, and by extension, the population, though its traits may neither be representative nor pressing in the context of unmet needs. In this manner, invoking a human rights violation would be akin to filing a class action, enabling all parties with a material interest in the case to be represented, regardless of any socioeconomic or other demographic barriers that may prohibit an individual claimant from bringing suit. Equity and efficiency become the hallmarks of this procedural device and appears quite attractive to advance a public health issue that, by definition, affects a number of persons who constitute the “population” of interest. Public health, however, is guided by efforts to prevent harm, and not merely to identify it in its most obvious, physical manifestation of a clinical diagnosis. Underlying this approach is the presumption that health is a social construct and any attempt to characterize the experience of

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illness must not relegate efforts to the clinical domain.<sup>1</sup> Rather, an explanation of the distribution and determinants of morbidity and mortality must necessarily identify factors further upstream, that is, within those components of social structure that are associated with health and well being. Bhattacharya's specific approach to enumerate the role of politics, epidemiology, ethics, economics, and law ("PEEEL" framework) influenced the draft revision of accreditation criteria for schools and programs in public health, which now specifically requires training in public health policy to encompass the precise inquiries into the disciplines of economics, ethics, and law.<sup>2</sup>

Incorporating social indicators into an epidemiological profile reifies a number of human rights principles, including their indivisibility, interdependence, and interrelatedness. Under the Universal Declaration of Human Rights, "[a]ll human beings are born free and equal in dignity and rights," yet securing fulfillment of human dignity through the satisfaction of unmet needs remains elusive.<sup>3</sup> A myopic approach that matches needs to rights removed from their social context may exacerbate health disparities and further marginalize those disproportionately affected by the burden of illness.

I propose a simplified, three-step framework: (1) constructing a social epidemiological profile of the affected population, (2) reviewing the legal landscape, including international, national, and sub-national law, and (3) drafting local policies through enacting novel, or amending the existing, laws and regulations. Parts I through III, discussed below, are dedicated to each of these steps, and utilize the experience of migrants in the U.S. as a case study to illustrate key themes and issues. By deliberating upon the people, problems, and possibilities, we may appreciate the utility of this approach, and identify future courses of action that simultaneously advance public health and human rights.

## I. The Necessity of Constructing a Social Epidemiological Profile

The relevance and utility of international law in advancing public health should not be relegated to a linear process of treaty ratification and subsequent enforcement of particular provisions. While this may seem at odds with prior (and even ongoing) efforts to advance the right to health, this traditional approach often distances itself from the practical constraints of public health policymaking and implementation. Moreover, this approach inaccurately assumes that observed effects vis-à-vis poor health outcomes or incidents of morbidity or mortality may be immediately traced to the absence of a statute, regulation, or an amendment. I have previously advanced a framework, captured by the mnemonic "PEEEL" to highlight the opportunities and challenges of public health policymaking by examining the role of politics, epidemiology, economics, ethics, and law. So while the law is a critical component of this broader framework, it

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<sup>1</sup> Dru Bhattacharya, *Public Health Policy: Issues, Theories, and Advocacy*, vii (2013).

<sup>2</sup> Council on Education for Public Health, Proposed Curriculum Criteria Revisions, C.4, t-v (2015) available at [http://ceph.org/assets/Draft\\_curriculum.pdf](http://ceph.org/assets/Draft_curriculum.pdf) (last visited October 22, 2015).

<sup>3</sup> Universal Declaration of Human Rights, G.A. Res. 217 (III) A, at Article 1, U.N. Doc. A/RES/217(III) (December 10, 1948).

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should not be examined in isolation because of the potentially confounding effects of the other elements.<sup>4</sup>

The benefits of this robust framework, however, extend beyond the seemingly inherent value of a comprehensive and interdisciplinary approach. Where a traditional legal inquiry might look for individual facts to support the potential violation of a right, a public health approach will scrutinize both the methods and information (or “data”) acquired by such efforts. Ideally, it will also disaggregate the data across numerous indicators that have historically amplified issues unique to the population under study. Examples may include age, sex, socioeconomic status, occupational hazards, access to material factors (e.g., food, shelter), as well as social and environmental determinants. Additionally, a traditional legal approach is quite reflexive, invariably following some blatant manifestation of a harm or wrong. Reporting violence, for example, and particularly incidents of sexual harassment or assault, has historically received attention among researchers exploring the experiences of female migrant workers. Our approach, however, would prioritize measures to combat violence as part of a broader strategy to promote health and secure the dignity of women. So before letting the data guide the development of policy, there should be a determination that the data is consistent with the unmet needs of the community being served. Even the term “unmet need” requires clarification, as it can be narrowly construed to mean the absence of a particular service or the heightened morbidity and mortality associated with a spike in the incidence of an illness. Otherwise, the provision of services, albeit beneficial, may not alleviate the burden of illness or address other needs that enable debilitating trends to sustain.

### A. The Inadequacy of Traditional Frameworks

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) espoused the initial right to health, identifying four specific steps to achieve the full realization of this right: (1) forging a provision for the reduction of the stillbirth and infant mortality rates; (2) improving all aspects of the environment and industrial hygiene; (3) preventing, treating, and controlling epidemic, endemic, and occupational diseases; and (4) creating conditions which would ensure medical services and medical assistance.<sup>5</sup> Notably, the right to health in the ICESCR was not explicitly synonymous with the right as was conceived by the World Health Organization. In its Constitution, the WHO made explicit reference to physical, mental, and social health. The omission of a “social” dimension to health in the ICESCR later prompted the Committee on Economic, Social, and Cultural Rights (CESCR) to clarify the apparent snub within a general comment that provided, in part, that the “express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic

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<sup>4</sup> Bhattacharya, *supra* note 1, at 431.

<sup>5</sup> International Covenant on Economic, Social and Cultural Rights, S. Treaty Doc. No. 95-19, 6 I.L.M. 360, 993 U.N.T.S. 3, at Article 12(2)(a)-(d) (Dec. 16, 1966).

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factors. . .”<sup>6</sup> Embracing a myriad of factors in a subsequent commentary, however, is quite distinct from an explicit obligation to do so.

In practice, the translation of the right to health would lay a foundation for the health and human rights movement, which has gathered momentum. We have begun to see studies that highlight the linkages between social structure and health. A prominent example of this is Michael Marmot’s depiction of three factors through which social structure influences health and well-being: 1) material, 2) occupational, and 3) social/environmental.<sup>7</sup> Jonathan Mann provided a related framework arguing that violations of human rights have foreseeable effects on health, as well as the policies that enabled such violations to remain/thrive.<sup>8</sup> Mann further argues that there is an inextricable linkage between health and human rights so that the promotion of one would invariably promote the other, thereby suggesting a synergistic effect between measures to secure health and rights. The WHO elaborated on these linkages in its health and human rights paradigm, identifying the utility of this framework to identify violations, reduce vulnerability, and promote health.<sup>9</sup>

Gostin and Mann<sup>10</sup> later proposed a 7-step framework for conducting a health and human rights assessment, followed by a comparable framework by Gostin and Lazzarini.<sup>11</sup> Although there are slight (albeit significant) differences between the frameworks, they are substantially consistent in their methodology and scope (summarized in Figure 1 below). We will attempt to match and review the corresponding steps, along with notable differences, to illustrate where and how our current approach departs from these traditional paradigms.

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<sup>6</sup> U.N. Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

<sup>7</sup> Marmot, Michael, and Richard Wilkinson, eds, *SOCIAL DETERMINANTS OF HEALTH* (Oxford U. Press, 2005).

<sup>8</sup> Jonathan Mann et al., *Health and Human Rights*, *HEALTH AND HUM. RIGHTS*, 6-23 (1994).

<sup>9</sup> World Health Organization, *Linkages between Health and Human Rights*, available at: <http://www.who.int/hhr/HHR%20linkages.pdf> (last visited October 22, 2015).

<sup>10</sup> Lawrence Gostin & Jonathan N. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 *HEALTH AND HUM. RIGHTS*, 59, 61-77 (1994).

<sup>11</sup> LAWRENCE GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC*, 58-67 (1997).

**Figure 1. Gostin and Mann’s vs. Gostin and Lazzarini’s Frameworks**

Gostin and Mann (1994)	Gostin and Lazzarini (1997)
<ol style="list-style-type: none"> <li>1. Clarify the public health purpose</li> <li>2. Evaluate likely policy effectiveness</li> <li>3. Determine whether the public health policy is well-targeted</li> <li>4. Examine each policy for possible human rights burdens</li> <li>5. Determine whether the policy is the least restrictive alternative to achieve the public health objective</li> <li>6. If a coercive public health measure is truly the most effective, least restrictive alternative, base it on the “significant risk” standard</li> <li>7. If a coercive measure is truly necessary to avert a significant risk, guarantee fair procedures to persons affected</li> </ol>	<ol style="list-style-type: none"> <li>1. Find the facts</li> <li>2. Determine if the public health purpose is compelling</li> <li>3. Evaluate how effectively the policy would achieve the public health purpose</li> <li>4. Determine whether the public health policy is properly targeted</li> <li>5. Examine each policy for possible human rights burdens</li> <li>6. Determine whether the policy is the least restrictive alternative that can achieve the public health objective</li> <li>7. If a coercive measure is truly the most effective, least restrictive alternative, base it on the “significant risk” standard and guarantee fair procedures</li> </ol>

The first step in Gostin and Mann’s framework calls for clarifying the public health purpose. This is problematic because articulating goals presupposes a consensus on the problem. Gostin and Lazzarini correct this by requiring an initial fact-finding expedition, and point to the “sciences” of public health and health-care (e.g., medicine, nursing, social services).<sup>12</sup> These suggestions, however, are medically centered sciences, and epidemiology is not a pure science but rather a set of methods to describe the distribution of morbidity and mortality, and their application to the control and prevention of disease. With the increasing appreciation of the role of social determinants, reliance on these “sciences” of public health would offer little insight into those factors (except for the discipline of social epidemiology, to which we shall return momentarily). While a single individual may be subject to a human rights violation, it is the systematic targeting of marginalized populations and the disproportionate burden they incur on account of social factors (e.g., religious beliefs, lower socioeconomic status, race/ethnicity, sex, etc.) that illustrates those populations disproportionately affected by the burden of illness. While a limit to the disciplines that we rely upon to characterize a public health problem is not necessary, the aforementioned fields are necessary, but insufficient.

The second step of Gostin and Mann’s framework recommends evaluation of the likelihood of the policy’s effectiveness. They elaborate on effectiveness by citing screening programs to demonstrate the importance of considering the context of interventions. Specifically, they cite the appropriateness and accuracy of tests, the likelihood of effective interventions, and the possibility of alternative approaches as criteria to be considered. This step essentially requires that a policy support interventions that are evidence-based and scrutinized to ensure minimal harm to affected populations (overlapping with steps 4 and 5). Given the

<sup>12</sup> *Id.* at 58.

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varied strengths of epidemiological studies, acknowledging the precise evidentiary basis for interventions is a critical step and may be cited within a social epidemiological profile, as discussed below. A randomized control trial may be the gold standard to illustrate why one drug may be preferred to another, but it tells us nothing of the communities and the underlying causes of the burden of illness. The critical issue, therefore, is not merely the strength of a particular piece of evidence, but whether the evidence is related to the unmet needs of the community, thereby begging the question of scope rather than merely substance.

The second step of Gostin and Lazzarini's approach is different and requires determination that the public health purpose be compelling. Here, the description of the criteria conflates the data with its interpretation, as if the former would necessarily translate into the latter. A rate (or any other indicator that constitutes those "facts" accumulated under Step 1) cannot have an inherent purpose, though it may be used to fulfill a purpose. If the standard is simply an aggregate sum, or some predetermined threshold worthy of "population" significance, then locating a *compelling* reason to intervene is nothing more than a formality in attaching the label thereto. Herein lies a fundamental problem with both frameworks; we are never quite sure when a health issue is a public health issue. A utilitarian model would suggest that health issues affecting, or potentially affecting, a large number of individuals are worthy of being considered "public health" issues.<sup>13</sup> This myopic view of public health would do little to advance health education and health promotion activities, which may take time to prevent future harm, especially as it relates to chronic illness. The role of childhood obesity, for example, as it relates to the adult onset of diabetes and other chronic health problems may not be readily apparent by examining a sample of children and screening them for such ailments. Yet, the role of those risk factors, and the benefits of advancing protective factors, may be worthy of scrutiny. Now childhood obesity is an easy "fact" to screen for in and of itself, and has drawn enough public attention in both professional and political arenas to satisfy a compelling public health purpose. What are not, but perhaps ought to be, more compelling issues are the social determinants<sup>14</sup> that sustain such trends, notwithstanding the extensive edu-

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<sup>13</sup> See *infra*, note 1.

<sup>14</sup> See World Health Organization, *What are Social Determinants of Health?* Available at: [http://www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/) ("The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.")(emphasis in the original); see also Centers for Disease Control and Prevention, *Determinants of Health*, <http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html> ("Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.") There is considerable overlap in how we generally characterize social determinants of health. The following definitions provided by the World Health Organization, and the U.S. Centers for Disease Control and Prevention together show the degree of similarities. Beyond those similarities, however, are some notable points in how the organization might choose to utilize those definitions to address issues in public health. The WHO defines social determinants as conditions in which people are born, grow, live, work and age. It goes on, however, to pinpoint these determinants as being responsible for health inequities, or what it describes as unfair and avoidable differences in health status, whether it is within or between countries. The CDC definition captures the breadth of determinants across many different spheres, including biological, socioeconomic, psychosocial, behavioral, and social. The organization notes that these forces are shaped by economics, social policies, and politics, and focuses on five determinants that it claims

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cational campaigns, and occasional targeted intervention (e.g., soda tax, removal of vending machines in schools) that are conveniently symbolic, perhaps even sustainable, but woefully distracting.

The social and behavioral sciences constitute a vital role in contextualizing facts, but they are not required indicators in a formal epidemiological investigation. This creates a potential gap that is critical and warrants elaboration to illustrate why this complexity must be identified and deliberately acted upon to tease out those indicators worthy of further scrutiny. The social patterning of health enables advocates to inquire into the broader societal context, the role and influence of social structure, and all those elements we have come to characterize as social determinants of health. Another important discipline is psychology, which has long been associated with mental health issues, but has come to encompass other areas including health psychology.

Sociological theories can be characterized into structural and social action theories, the latter of which is espoused by Max Weber. Of course, our understanding of illness and ascribing those accommodations are by no means simple, especially when we publicly treat individuals differently for the behaviors that may have contributed to those ailments. We have seen this historically with the use of alcohol, tobacco, perhaps the contraction of an infectious disease, most notably HIV/AIDS, and perhaps today with overweight and obesity.<sup>15</sup> So our response is by no means simple, and for conditions that we find entangled in a web of societal influences that may exacerbate the experience or disparities within a particular subgroup—along the lines of sex, age, race/ethnicity, or socioeconomic status—the opportunity and constraints to intervene become more elusive because of the myriad of options that vary across different levels and time.<sup>16</sup> The emphasis, however, is objectivity wherein these determinants may be measured within dimensions and components using precise indicators.<sup>17</sup> Globalization with respect to the geopolitical, economic, and environmental dynamics has only added another layer to this complexity. Therefore, we ought to refrain from reflexive judgment about a given issue until we have appreciated the breadth of factors that may contribute to the experience of illness.

When we look at the sphere of human behavior, we can identify a wide set of risk regulators. Glass and McAtee describe behavior as an emergent property of the interplay between opportunities and constraints emanating from the environ-

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scientists have generally recognized: first, biology and genetics (such as sex and age); second, individual behavior (such as alcohol use, smoking, unprotected sex); third, the social environment (such as income, and discrimination); fourth, the physical environment (such as where a person lives); and finally, health services (such as access to care, and insurance coverage). The CDC also collects data on these determinants as being consistent with its mission to “reduce health inequities among populations most disproportionately affected by HIV, AIDS, STDS, TB, and hepatitis.”

<sup>15</sup> See, e.g., Ronald O. Valdiserri, *HIV/AIDS stigma: an impediment to public health*. 92(3) AM. J. PUB. HEALTH 341 (2002).

<sup>16</sup> See, e.g., Marilyn Metzler, *Social determinants of health: what, how, why, and now*. 4(4) PREVENTING CHRONIC DISEASE A85 (2007).

<sup>17</sup> See, e.g., Marianne Hillemeier et al., *Data Set Directory of Social Determinants of Health at the Local Level*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2004).



ment.<sup>18</sup> Here, we detail that environment to include material conditions; discriminatory practices, policies and attitudes; neighborhood community conditions; behavioral norms, rules, and expectations; conditions of work; and laws, policies, and regulations.<sup>19</sup> How do we explore these factors? Social action theories, which emphasize subjectivity, require researchers to focus on focus groups, interviews, surveys, and related qualitative assessments to collect data on beliefs, attitudes, and practices. Let us return to our example of childhood obesity to demonstrate the complexity of the problem.

Skelton et al. reported that more U.S. children are becoming severely obese after conducting a survey of 12,000 U.S. children and adolescents, ages 2-19 (Severe obesity is a BMI = 99th percentile for age and gender, and they found that the prevalence tripled from 0.8% ('76-'80) to 3.8% ('99-'04)).<sup>20</sup> In the U.S., instituting a soda tax would easily satisfy either of the initial steps of the aforementioned frameworks owing to this scope and magnitude of childhood overweight and obesity, coupled with evidence from a meta-analysis that a tax on sugar sweetened beverages reduces the obesity rate.<sup>21</sup> But why is this approach any more compelling than efforts to intervene with stakeholders such as parents, children, or schools, as loci of reform? We can conceptualize parents with respect to their awareness and health and the role of the home setting and environment. With children specifically, we may refer to the role of activities such as video games, food choices, and adolescent awareness of weight status. And with schools, we may consider the time spent in school, food, the school's environment, opportunities for physical activity, and education as important factors that affect a child's health.

The home environment and role of parents is remarkable, as obese parents appear to be more likely to have overweight children. A study done by Trasande focused on 226 families and determined that 41% of 8-year-old daughters of obese mothers were themselves obese. In contrast, only 4% of girls were obese who had mothers of a normal body weight.<sup>22</sup> Parents may also lack confidence to implement healthy behavior changes for children. Taveras et al. conducted a survey of 446 parents of overweight children, aged 2-12, about how confident they felt in making changes aimed at television viewing, and reducing their children's consumption of fast food. The mean parental confidence was 13 on a scale of 0-24.<sup>23</sup> Moreover, parents with positive outlooks on team sports have more active

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<sup>18</sup> Thomas Glass & Matthew J. McAtee, *Behavioral Science at the Crossroads in Public Health: Extending Horizons, Envisioning the Future*, 62 SOC. SCI. & MED. 1650, 1660 (2006) (opportunities and constraints constituting "structural contingencies").

<sup>19</sup> *Id.*

<sup>20</sup> Joseph A. Skelton et al., *Prevalence and Trends of Severe Obesity among U.S. Children and Adolescents*, 9 ACAD. PEDIATRICS 322-329 (2009).

<sup>21</sup> Maria A. Escobar et al., *Evidence that a Tax on Sugar Sweetened Beverages Reduces the Obesity Rate: a Meta-Analysis*, 13 BMC PUB. HEALTH 1072 (2013).

<sup>22</sup> Leonardo Trasande et al., *Effects of Childhood Obesity on Hospital Care and Costs, 1999-2005*, 28 HEALTH AFFAIRS w751-w60 (2009).

<sup>23</sup> Elsie Taveras et al., *Parental Confidence in Making Overweight-Related Behavior Changes*, 124 PEDIATRICS 151 (2009).

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children. A study by Anderson and Hughes included a survey of 680 parents of 4th and 5th graders from 12 schools. Children were more physically active when parents conveyed the importance of high-intensity team sports.<sup>24</sup> Overweight mothers are also less likely to accurately identify their children's weight. A study by Warschburger and Kroller entailed a survey of 216 mothers of children, aged 3-6, and asked to assess the weight status of 36 gender-specific silhouettes representing different ages and body mass indices.<sup>25</sup> Only 64.5% identified the silhouettes correctly and only 48.8% associated overweight silhouettes with a health problem.<sup>26</sup> Infants cared for in another home are also likely to be heavier. Benjamin et al. conducted a study of 1,100 women while pregnant and assessed weight after assessing who was placed in some form of day care.<sup>27</sup> Children cared for in someone else's home were more likely to be heavier than if they were either at home or in day care.<sup>28</sup> And finally, parents' dietary restrictions may backfire. Anzman and Birch conducted a study of 200 non-Hispanic white females and parents at two-year intervals when the girls were ages 5-15. They measured the mothers' reports of girls' inhibitory control levels, girls' reports of parental restriction, girls' BMI, and found that girls with lower inhibitory control at age 7 had higher concurrent BMI, greater weight gain, and higher BMIs later.<sup>29</sup>

The behaviors and beliefs of adolescents are also compelling factors. Online games, for example, can influence food choices. Pempek and Calvert conducted a study of 30 children, age 9-10, to play a game that awarded points for selecting healthy foods; a second version rewarded selection of unhealthy foods.<sup>30</sup> They measured the children's choice of a snack after playing, and found that 90% of children who played the first game chose a healthy snack, while only 10% did the same in the second group.<sup>31</sup> Adolescents also frequently underestimate body weight. Wang et al. conducted a survey of 196 boys and 252 girls, 5th through 8th grades, about their body weight, body perception, and weight control behaviors.<sup>32</sup> They found that 36% of overweight boys and 21% of overweight girls

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<sup>24</sup> Cheryl B. Anderson et al., *Parent-child Attitude Congruence on Type and Intensity of Physical Activity: Testing Multiple Mediators of Sedentary Behavior in Older Children*, 28 *HEALTH PSYCHOL.* 428, 436 (2009).

<sup>25</sup> Petra Warschburger & Katja Kröller, *Maternal Perception of Weight Status and Health Risks Associated with Obesity in Children*, 124(1) *PEDIATRICS*, 1 at e60-e68 (2009).

<sup>26</sup> *Id.*

<sup>27</sup> Sara E. Benjamin et al., *Early Child Care and Adiposity of Ages 1 and 3 Years*, 124(2) *PEDIATRICS* 555, 560 (2009).

<sup>28</sup> *Id.*

<sup>29</sup> Stephanie L. Anzman & Leann L. Birch, *Low Inhibitory Control and Restrictive Feeding Practices Predict Weight Outcomes*, 155(5) *THE J. OF PEDIATRICS* 651, 653 (2009).

<sup>30</sup> Tiffany A. Pempek & Sandra L. Calvert, *Tipping the Balance: Use of Advergaming to Promote Consumption of Nutritious Foods and Beverages by Low-income African American Children*, 163(7) *ARCHIVES OF PEDIATRICS & ADOLESCENT MED.* 633-37 (2009).

<sup>31</sup> *Id.*

<sup>32</sup> Youfa Wang et al., *Measured Body Mass Index, Body Weight Perception, Dissatisfaction and Control Practices in Urban, Low-income African American Adolescents*, 9 *BMC PUB. HEALTH* 183, 186, 190-91 (2009).

reported that their weight was normal or underweight, and 43.4% reported attempting to lose weight, although those who said so did not eat healthier or appear more active than those who did not report attempting to lose weight.<sup>33</sup>

The role of schools has been instrumental in providing access to food for children for many decades. The Healthy, Hunger-Free Kids Act of 2010 funds a number of nutrition programs, including the National School Lunch program. Over 45% of U.S. youth participate in this program, which costs approximately \$12 billion annually and serves 32 million children. The National School Lunch Program provides nutritionally balanced meals at either low or no cost, and can be traced back to 1946 when President Harry Truman signed the National School Lunch Act.<sup>34</sup> It operates in over 100,000 public and non-profit private schools and residential child care institutions.<sup>35</sup> The lunches have to meet the nutritional standards in the latest Dietary Guidelines for Americans, and there are set calorie limits based on grade levels and improvements based on gradual reductions in sodium content. For example, it includes targets that must be reached in future years. Local school food authorities ultimately choose the foods served to the children, and schools receive support in the form of a cash reimbursement for each meal served.<sup>36</sup> The program has encountered significant challenges amidst reports of wasted food and improper payments alongside continued rates of childhood obesity, prompting Congressional hearings on the matter.<sup>37</sup> There have also been reports in schools of children selling packets of sugar or other condiments in order to mitigate the bland taste of some foods.<sup>38</sup>

Against this backdrop, we can appreciate a far more complex landscape to address childhood overweight and obesity and the need to adopt a nuanced approach that appreciates the numerous stakeholders and points of intervention. The role of social and behavioral sciences in public health amplifies the social structure and behavioral determinants of health. Whether we choose to adopt theories grounded in social structure or social action theory, we find opportunities to clarify the experience of illness associated with factors that extend beyond the proximal risk factors of disease. As we see in the example of childhood obesity, the role of parents, children, and schools as a loci of reform, numerous challenges arise in identifying the precise level and time of intervention to alleviate the burden of illness among vulnerable populations. By recognizing the opportunities and constraints, however, we may take a more nuanced approach to craft-

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<sup>33</sup> *Id.*

<sup>34</sup> Richard B. Russell National School Lunch Act, Pub. L. No. 79-396, 60 Stat.239 (codified as amended in scattered sections of 42 U.S.C.).

<sup>35</sup> United States Department of Agriculture, *National School Lunch Program Factsheet*, (September 2013), <http://www.fns.usda.gov/sites/default/files/NSLPFactSheet.pdf>.

<sup>36</sup> *Id.*

<sup>37</sup> Subcommittee on Early Childhood, Elementary, and Secondary Education, *Addressing Waste, Fraud, and Abuse in Federal Child Nutrition Programs* (May 19, 2015), available at: <http://edworkforce.house.gov/calendar/eventsingle.aspx?EventID=398843> (last visited October 22, 2015).

<sup>38</sup> Subcommittee on Early Childhood, Elementary, and Secondary Education, *Child Nutrition Assistance: Looking at the Cost of Compliance for States and School*, (2015), available at: [http://edworkforce.house.gov/uploadedfiles/payne\\_testimony.pdf](http://edworkforce.house.gov/uploadedfiles/payne_testimony.pdf).

ing and implementing interventions that will only increase our likelihood of obtaining marked improvements in health.

Subsequent steps to ensure that the policy is “well-targeted” in response to a “significant risk” is a low bar to meet because a policy that is not well-targeted would not be consistent with the evidence base, or at the very least, would reveal gaps in the epidemiological literature as to the representativeness of the samples used in the studies.

Additionally, it is unclear what constitutes a “significant” risk beyond a heightened probability of transmission, but locating the threshold of significance is not a dispositive issue. What is problematic with the standard is that it is an individual determination, albeit consistent with traditional human rights analyses, but inadequate for our purposes. We need a standard that does not utilize an individual as the object of an intervention, but rather the population. In doing so, we shift the frame of reference to scrutinize those factors that enable population wide disparities to remain. These considerations may therefore be folded into the prior discussion of the evidence-base.

Gostin and Mann introduced four criteria to assess a human rights burden (Steps 4 and 5): (1) the nature of the human right, (2) invasiveness of the intervention, (3) the frequency and scope of the infringement, and (4) its duration.<sup>39</sup> These criteria are consistent with assessments of overt acts, and are thereby appropriate for downstream determinations. Unfortunately, these considerations may be too late and ought to be complemented by an upstream determination of social structure. By adopting this broader perspective, we are no longer confined to those indicators predictably defined by the intervention, but can focus more on the underlying causes of the burden of illness. Consider a heightened incidence of chronic disease within a community. Enabling access to care, and the provision of basic medical services (e.g., treatment) is a somewhat obvious proposition. At the same time, these provisions do not reach the following questions: Why did this particular population become affected? Do they share characteristics that suggest that they were at a heightened probability of disease onset? If so, what protective factors—rather than risk factors—ought to be promoted within this community to reduce the likelihood of infection? To answer these questions, we have to first assess the broader unmet needs of the community. Notably, there is no human right to public health, and individuals must lean on governmental discretion as to which indicators are sufficiently relevant to warrant a particular course of action.

Determining whether the policy is the least restrictive alternative that can achieve the public health objective does not require elaboration. To do otherwise would simply be unethical. A more challenging proposition is determining the least restrictive alternative in modifying a social determinant. In practice, this entails discretion because we do not have a hierarchy of pathways from social structure to health and well-being. Marmot’s classic framework articulates three

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<sup>39</sup> Lawrence Gostin & Jonathan N. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 HEALTH AND HUMAN RIGHTS 59, 61-77 (1994).

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pathways through material, occupation, and social/environmental factors; yet, consistent with the principles of indivisibility and interrelatedness of human rights, the interrelated dimensions of these social determinants as material factors may be affected by occupational factors, which in turn may be affected by social/environmental factors (and vice versa). An allocation of resources that targets these determinants ought to be informed by the weight of influence that the particular pathway has at a given time for a given population; that is, handled on a case-by-case basis that, again, may be folded back into a social epidemiological profile, which ought to capture the weight of those factors.

The final steps entail the provision of fair procedures to persons affected by coercive measures.<sup>40</sup> This is a fundamental right whose implications are less a matter of public health concern, since the health issue to be averted is supposedly accomplished by the restraint of the individuals. Insofar as they cannot escape from this restraint, the public health issue has been addressed, albeit crudely, and begs the question whether voluntary submission to this restraint would alter the criteria. For example, if an at-risk individual isolates himself, or an infected individual quarantines herself, securing access to counsel (whether through public or private assistance) is neither an exceptional nor health-promoting feat. The right of habeas corpus is perhaps among the select rights that may find consensus in any legitimate democracy, but it does not seem to add much value to our framework (save in the case of infectious diseases where an incubation period may be cited to inform the length of detainment. But again, this would be distinct from the general provision of legal counsel).

Together, these considerations suggest that the traditional frameworks are untenable, and we turn towards a more nuanced approach that simplifies the process, and advances public health through a more deliberate course of action.

### B. Incorporating a Social Epidemiological Profile: Migrant Workers in California

A migrant worker is “a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.”<sup>41</sup> Over 214 million people meet this definition, whose plight may have stemmed from political persecution, conflicts, natural disasters, poverty, or even the pursuit of education or employment.<sup>42</sup> Here, we introduce the utility of integrating a social epidemiological profile into health and human rights assessments.

The shortcomings of our traditional models are not limited to theoretical constructs, but severely limit our range of intervention to satisfy unmet needs. There is no singular definition of an unmet need, so we may define the term narrowly with respect to access to a particular service, or broadly with respect to underlying social conditions that may directly, or indirectly, be associated with the health

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<sup>40</sup> Gostin, Mann, and Lazzarini, *supra* notes 10-11.

<sup>41</sup> International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families art. 2(1), Dec. 18, 1990, 2220 U.N.T.S. 93.

<sup>42</sup> Pia Oberoi et al., *International Migration, Health, and Human Rights*, 7 (2013).

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and well-being of the target population. Therefore, scrutinizing the adequacy of measures to secure the right to health by effectively meeting an unmet need can be elusive. What balance ought to be struck between the provision of preventive and therapeutic measures? What benchmarks should be established and over what period of time? Historically, no explicit guidelines were issued vis-à-vis the conventions or general commentary on the right to health.

In practice, determining the unmet health needs is best accomplished by examining the characteristics of the affected communities. We may accomplish this by creating an epidemiological profile of a community and including precise calculations of health indicators and an assessment of the laws and policies that affect the distribution and determinants of those indicators. An epidemiological profile is a report of the distribution of an ailment within various populations in a defined geographic region. The creation of an HIV/AIDS epidemiological profile, for example, would include an assessment of characteristics of the general population, individuals infected with HIV, and individuals at risk of infection.<sup>43</sup> The profile would also include data on the effect of HIV/AIDS on that community with respect to socioeconomic, geographic, behavioral, and clinical factors.<sup>44</sup>

The standard epidemiological profile would fit neatly within the traditional frameworks above by providing facts that would be compelling by their sheer scope and magnitude. For illustrative purposes, we shall focus on migrant workers as a case study to demonstrate the utility of this approach. We will create a simple epidemiological profile, illustrated below, of migrant patients who attended 160 health centers, and highlight the burden of diabetes that disproportionately affects individuals of Hispanic ethnicity, age 45 and above.

**Table 1. Traditional Epidemiological Profile of Migrants**

	Most Frequent Visits by 1° Diagnosis	Visits per Patient	Hispanic Ethnicity	Adults > 45 enrollment	Overweight or obese dx
Migrants	Diabetes	3.09 <sup>45</sup>	89.8% <sup>46</sup>	20.7% <sup>47</sup>	4th

Against this backdrop, implementing a lifestyle intervention that targets adult Hispanic migrants who are overweight or obese would reduce the risk of diabe-

<sup>43</sup> Centers for Disease Control and Prevention and Health Resources Services Administration, *Integrated Guidelines for Developing Epidemiologic Profiles*, (2004), available at: <http://www.cdph.ca.gov/programs/aids/Documents/GLines-IntegratedEpiProfiles.pdf>.

<sup>44</sup> *Id.* at 3.

<sup>45</sup> U.S. Dep't of Health and Hum. Servs., *National - Migrant Health Center - 160 Grantees, List of Grantees - 2011* 15 (2011), [http://bphc.hrsa.gov/uds/doc/2011/National\\_mh.pdf](http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf) (table 6A, line 9, visits per patient).

<sup>46</sup> *Id.* at 8 (table displaying patients by race).

<sup>47</sup> *Id.* (estimated 164,966 calculated from summing lines 30-38 and dividing by the total 795,808, yielding .207 or 20.7%).

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tes.<sup>48</sup> Overweight and obesity are risk factors particularly for individuals, age 45 and above, who are at heightened risk of developing the illness.<sup>49</sup> Since Hispanic males constitute almost 90% of this population, identifying those individuals who are overweight or obese would satisfy the “significant risk,” “compelling” health purpose, and “well-targeted” policy criteria.

A social epidemiological profile, however, is a critical addendum to this traditional approach that incorporates social and historical determinants.<sup>50</sup> While the specific variables will differ on a case-by-case basis, the types of indicators would be similar insofar as they highlight social determinants. Notably, these determinants may change over time. Back in 1938, Dr. Walter Dickie, the Medical Director of the California State Department of Public Health, issued a report on migrant health in the department’s weekly bulletin.<sup>51</sup> Dr. Dickie noted that the migrant population at the time was 90% White with malnutrition and poor dietary habits among the chief health related concerns.<sup>52</sup> Low-calorie intake and the absence of essential nutrients and minerals were among the specific findings. Notably, migrant mothers were said to be “[not used to] preparing the variety of vegetables and fruits” available in the state, so the health department placed nutritionists alongside doctors and nurses, and they held classes to give individual instruction to mothers on food preparation.<sup>53</sup> The Department of Agriculture also provided food grants and commodities for these families whose health improved in the months after receiving this aid.<sup>54</sup> At that time, infectious diseases such as tuberculosis were prevalent but were no greater among the children of migrants than the local residents. The health department concluded that the greatest need in this population was “that of education in the hygiene of proper living.”<sup>55</sup> It also requested a coordinated effort by social welfare, medicine, nursing, and public health across local, state, and federal agencies to bring this population within the “social life of California.” The report concluded by recommending not merely services for the prevention of disease alone, but additional care, relief, and housing facilities. The laws did predicate access to county hospitals based upon legal residence, but when that was lacking, migrants were directed to private physicians with services paid for by the Agricultural Health and Medical Association.<sup>56</sup>

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<sup>48</sup> See, e.g., Diabetes Prevention Program (DPP) Research Group, *The Diabetes Prevention Program (DPP): Description of lifestyle intervention*, 25(12) *DIABETES CARE* 2165-71 (2002).

<sup>49</sup> Mayo Clinic Staff, *Disease and Conditions: Type 2 Diabetes*, <http://www.mayoclinic.org/diseases-conditions/type-2-diabetes/basics/risk-factors/con-20031902>.

<sup>50</sup> Luis A. Avilés, *Epidemiology as Discourse: the Politics of Development Institutions in the Epidemiological Profile of El Salvador*, 55(3) *JOURNAL OF EPIDEMIOLOGY AND COMTY. HEALTH* 164-71 (2001).

<sup>51</sup> Walter M. Dickie, *Health of the Migrant*. *WEEKLY BULLETIN, CAL. DEP’T OF PUB. HEALTH* 81-87 (June 18, 1938).

<sup>52</sup> *Id.* at 81.

<sup>53</sup> *Id.* at 83.

<sup>54</sup> *Id.*

<sup>55</sup> *Id.* at 86.

<sup>56</sup> *Id.*

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Over the past 70 years, we have seen a shift in the demographic makeup and the unmet needs of the migrant community. Today, the Health Resources and Services Administration reports that 81% of migrants are at or below federal poverty level, 51% are uninsured, and 90% are Hispanic or Latino (See Table 2, above). Diabetes and hypertension rank highest among select medical conditions, and preventive and screening services related to women and maternal and child health are among the highest within that category.<sup>57</sup> Specific measures include contraceptive management, the PAP test, and health supervision of an infant or child. Nutritional deficiencies still abound, with overweight and obesity high among the primary diagnoses at a first visit with a healthcare provider.<sup>58</sup>

So we observe an expansion of unmet needs specific to female migrants in their roles as both women and mothers, and an additional element of race and ethnicity that must be accounted for given cultural, linguistic, and other related issues that may give rise to discrimination and barriers to access and care. There is no single or comprehensive data repository for this population with some estimates based on assessments conducted 10-15 years prior. Therefore, studies conducted by researchers become a valuable source of information to identify existent trends that may otherwise go undetected based on current reporting requirements and compliance with these requirements.

For purposes of illustration, the social epidemiological profile in Table 2 includes individuals living at or below the federal poverty level, insurance status, ethnicity, and a history of workplace harassment, painting a broader picture of the migrant experience.

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<sup>57</sup> U.S. Dep't of Health and Hum. Servs., *National - Migrant Health Center – 160 Grantees, List of Grantees – 2011 15* (2011), available at: [http://bphc.hrsa.gov/uds/doc/2011/National\\_mh.pdf](http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf).

<sup>58</sup> *Id.*



**Table 2. Social Epidemiological Profile of Migrants**

	Most Frequent 1° Diagnosis	At or below FPL	Uninsured	Hispanic Ethnicity	Medicaid enrollment	Workplace harassment
General Pop	Hypertension <sup>59</sup>	15% <sup>60</sup>	11.4% <sup>61</sup>	17.0%	22.5% <sup>62</sup>	25% <sup>63</sup>
Migrants	Hypertension <sup>64</sup>	81%	51.0% <sup>65</sup>	89.8% <sup>66</sup>	37.3% <sup>67</sup>	0%-97% <sup>68</sup>
Difference	—	+66%	+39.6%	+72.8%	+14.8%	+72%

Heart disease is the leading cause of death among all Americans, including Hispanics.<sup>69</sup> Although the most frequent number of *visits* were attributable to diabetes, hypertension—a risk factor for heart disease—was the most frequent primary diagnosis for all patients.<sup>70</sup> Individuals without insurance, or who have inadequate access to healthcare, have a heightened risk of developing cardiovascular disease.<sup>71</sup> This risk may be particularly pronounced among migrants who are more likely to be uninsured compared to the general population. Among migrant women, the magnitude of workplace harassment is particularly noteworthy. Harassment is a psychosocial stressor and studies have demonstrated that daily

<sup>59</sup> Centers for Disease Control and Prevention, *National Ambulatory Medical Care Survey:2010 Summary Tables*, 18 (2010), available at: [http://www.cdc.gov/nchs/data/ahcd/names\\_summary/2010\\_names\\_web\\_tables.pdf](http://www.cdc.gov/nchs/data/ahcd/names_summary/2010_names_web_tables.pdf) (noting “essential hypertension” was the most commonly diagnosed condition for physical office visits).

<sup>60</sup> Kaiser Family Foundation, *Distribution of Total Population by Federal Poverty Level*, (2014), available at: <http://kff.org/other/state-indicator/distribution-by-fpl/>.

<sup>61</sup> Stephanie Marken, *U.S. Uninsured Rate at 11.4% in Second Quarter*, Gallup (July 10, 2015), available at: <http://www.gallup.com/poll/184064/uninsured-rate-second-quarter.aspx>.

<sup>62</sup> Kaiser Family Foundation, *Total Monthly Medicaid and CHIP Enrollment*, (2014), available at: <http://kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/> (71,637,638 divided by national population of 318,900,000 = 22.5%).

<sup>63</sup> ABC News & Washington Post, *One in Four U.S. Women Reports Workplace Harassment*, (2011), available at: <http://www.langerresearch.com/uploads/1130a2WorkplaceHarassment.pdf>.

<sup>64</sup> Benjamin, *supra*, note 28, at 560.

<sup>65</sup> *Id.* at 10.

<sup>66</sup> *Id.* at 9.

<sup>67</sup> *Id.* at 10.

<sup>68</sup> Irma M. Waugh, *Examining the Sexual Harassment Experiences of Mexican Immigrant Farmworking Women*, 28 *VIOLENCE AGAINST WOMEN* 247 (2010) (notably, incidents of sexual assault, abuse, or related crimes were not included within HRSA’s summary of health-related diagnoses. She interviewed over 150 Mexican female farmworkers, of which over 97% reported an experience of harassment from male co-workers or supervisors. These findings illustrate the breadth of unmet needs, which encompass traditional clinical ailments alongside social determinants in the occupational and social environments); cf. Don Villarejo, *The Health of California’s Immigrant Hired Farmworkers*, 53(4) *AM. J. INDUS. MED.* 387, 392 (2010) (did not report a single instance of workplace violence, but also did not measure harassment, which is not an interchangeable term).

<sup>69</sup> Centers for Disease Control and Prevention, *Know the Facts about Heart Disease*, available at: [http://www.cdc.gov/heartdisease/docs/consumer\\_heartdisease.pdf](http://www.cdc.gov/heartdisease/docs/consumer_heartdisease.pdf).

<sup>70</sup> U.S. Dep’t of Health and Hum. Servs., *National - Migrant Health Center – 160 Grantees, List of Grantees – 2011 15*, (2011), available at: [http://bphc.hrsa.gov/uds/doc/2011/National\\_mh.pdf](http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf) (table 6A, line 9, visits per patient).

<sup>71</sup> Am. Heart Ass’n, *Hispanics and Heart Disease, Stroke*, [http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/Hispanics-and-Heart-Disease-Stroke\\_UCM\\_444864\\_Article.jsp](http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/Hispanics-and-Heart-Disease-Stroke_UCM_444864_Article.jsp) (last visited Oct. 26, 2015).

harassment and unfair treatment were significant predictors of *masked* hypertension, which is defined as a normal blood pressure in the clinic, but an elevated blood pressure outside of the clinic.<sup>72</sup> Moreover, masked hypertension is a risk factor for cardiovascular disease.<sup>73</sup> Of course, general estimates on workplace harassment do not imply that an intervention regarding the same would yield lower rates of masked hypertension and future cardiovascular disease in a specific population. Indeed, a follow up study on a specific migrant population should examine the outcomes for that particular population. Still, our breadth of understanding should give us pause. These considerations illustrate the rather arbitrary characterization of a public health problem devoid of its social context, and simultaneously demonstrate the simplicity and utility of the proposed framework. In this context, implementing interventions that simultaneously address the social and physical determinants of the health problem will alleviate the burden of illness experienced by the affected population.

The role of laws and policies that may give rise to inequalities in health should be discerned from a simultaneous review of the social epidemiological profile. An analysis that relies solely on applying principles of statutory interpretation to the text of a treaty, statute, or regulation would not necessarily correlate to the observed effect of the law in practice, and may even generate complacency based on the notion that the measure was evidence-based. The appeal of this traditional analysis is perhaps attributed to the assumption that the law is most relevant as a tool to promote public health through its coercive influence. In response to a recent outbreak of measles among children, numerous health professionals were quick to support legislation that mandated vaccination. In California, where the outbreak occurred, two legislators indicated their intent to introduce a bill that would remove the personal belief exemption that historically enabled parents to opt out of vaccinating their children based on religious or philosophical beliefs.<sup>74</sup> In a recent study on a pertussis (whooping cough) outbreak, researchers found that unvaccinated children were not driving the epidemic, but they did have a higher risk of pertussis infection than those who were vaccinated.<sup>75</sup>

Ironically, in another city within California, an outbreak of pertussis occurred despite high levels of vaccination within the affected community.<sup>76</sup> In that case, the outbreak was attributed to the waning effectiveness of the vaccine, which only affords 5 years of protection.<sup>77</sup> Although the effectiveness of vaccination is

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<sup>72</sup> Antoinette M. Schoenthaler et al., *Daily Interpersonal Conflict Predicts Masked Hypertension in an Urban Sample*, 23(10) AM. J. HYPERTENSION 1082-88 (2010).

<sup>73</sup> Donald W. McKay et al., *Masked Hypertension: A Common but Insidious Presentation of Hypertension*, 22(7) CANADIAN J. CARDIOLOGY 617-620 (2006).

<sup>74</sup> S. 277, 2015 Leg. (Cal. 2015) (enacted), available at: [http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb\\_0251-0300/sb\\_277\\_bill\\_20150219\\_introduced.html](http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0251-0300/sb_277_bill_20150219_introduced.html).

<sup>75</sup> Bridget M. Kuehn, *Author Insights: Protection from Pertussis Vaccine Wanes Over Time*, News at Jama (November 27, 2012), available at: <http://newsatjama.jama.com/2012/11/27/author-insights-protection-from-pertussis-vaccine-wanes-over-time/>.

<sup>76</sup> The Associated Press, *State Whooping Cough Outbreak Shows Vaccine Weakness*, San Diego Union Tribune (February 8, 2015), available at: <http://www.sandiegouniontribune.com/news/2015/feb/08/california-whooping-cough-outbreak-raises-vaccine/>.

<sup>77</sup> *Id.*

a public health truism, the reflexive insistence on a coercive mandate to remedy the public health problem paints an incomplete picture of the role of law in public health. Beyond coercion, the necessity to educate the public and conduct ongoing surveillance and monitoring of trends to inform subsequent epidemiological studies ought to be welcomed within the broader legislative and executive framework. In this way, laws ought to be crafted with an eye towards health promotion and the reduction of vulnerabilities through an iterative review of how well our laws and policies comport with the observed health outcomes. A health and human rights paradigm is therefore a powerful framework that compels advocates to lean on population health studies and assessments to capture the experience of the burden of illness. This burden is not narrowly confined to the physical ailment, but to the social forces that may create, sustain, or exacerbate those experiences. We now turn to an assessment of international and U.S. laws and policies in response to these unmet needs.

### II. Assessment of International and U.S. Laws and Policies

The human right to, and the interdependence of, health,<sup>78</sup> food, housing, and employment, are among the myriad of indicia that may guide an assessment of States' compliance with obligations under the respective international treaties. These measures are frequently invoked by treaty monitoring bodies and international organizations that may issue shadow reports to facilitate periodic review. An accounting of these rights, however, does not necessarily secure the conditions to promote health.

Even attempts to identify or infer elements of formal or substantive equality to advance *de jure* or *de facto* equality among the sexes do not necessarily translate into the realization of public health. The provision of healthcare services, for example, is necessary but insufficient, as well as the broader assurance of access to health insurance. At first blush, it may be tempting to attribute this shortcoming to the difference between healthcare and public health, a distinction that has in fact given rise to arguments for recognizing a unique right to public health. I do not belabor this distinction but rather draw upon a fundamental premise that health—whether actualized at the individual or population levels—is fundamentally a social construct, and as such, the right to health inheres in social determinants further upstream from the delivery of healthcare services. Increasing access to medications to control diabetes and examining social barriers to secure education, employment, and economic opportunity, ought to be part of a broader public health policy.

We begin with a review of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), two general recommendations issued by its treaty monitoring body, and a WHA resolution on migrant workers to identify the health indicators and rights language that may be helpful in shaping our domestic legislation and policies. I then examine U.S. federal law on migrant

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<sup>78</sup> International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200A (XXI), art. 12, U.N. Doc. A/RES/2200(XXI)A (Dec. 16, 1966).

workers and the potential availability of private rights of action to illustrate existing gaps.

A. CEDAW, General Recommendations, and WHA Resolution 61.17

*CEDAW Article 12*

The health provision in CEDAW was drafted narrowly to support (1) access to contraceptives and (2) care during the prenatal, delivery, and postnatal periods for expectant mothers.<sup>79</sup> The experience of female migrants across 160 health centers indicates that both of these measures are essential this population.<sup>80</sup> Over 102,000 visits occurred in 2011 for contraceptive management among 58,000 patients, averaging almost two visits per patient.<sup>81</sup> This was the fourth highest preventive service sought after by women following immunizations, the seasonal flu vaccine, and services related to the health supervision of the infant or child.<sup>82</sup> This latter service speaks to the second provision of CEDAW, which focuses on maternal and child health. In 2011, there were over 168,000 such visits among 108,000 patients, or a little over 1.5 visits per patient. Out of 14 selected diagnostic tests and preventive services, access to contraceptive management and maternal and child health were among the leading service categories for migrants. The health provision is therefore consistent with the data on unmet needs of female migrants as relates to women's health issues.

*General Recommendations 24 and 26*

In 1999, or twenty years following the Convention, the CEDAW Committee issued General Recommendation 24 to elaborate on the health provision.<sup>83</sup> Over 19 sessions of State Party reports, coupled with programs of action adopted at United Nations (U.N.) world conferences, the work of the World Health Organization (WHO), United Nations Population Fund (UNFPA), and numerous non-governmental organizations (NGOs), contributed to the language of the recommendation. The Committee drew particular attention to societal factors and requested special attention to the needs of the most vulnerable and disadvantaged groups, and first on its list were migrant women. Specifically, the Committee requested future reports to demonstrate that health legislation, plans, and policies were based on scientific and ethical research and assessment of the health status and needs of women.<sup>84</sup> It also requested to take into account ethnic, regional, or community variations based on religion, tradition, or culture.<sup>85</sup> The Committee

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<sup>79</sup> Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, art. 12, U.N. Doc. A/RES/34/180 (Dec. 18, 1979).

<sup>80</sup> U.S. Dep't of Health and Human Servs., *supra* note 71 at 15 (table 6A, line 9, visits per patient).

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> Report of the Committee on the Elimination of Discrimination against Women, G.A. Res. A/54/38, U.N. Doc A/RES/54/38 (May 4, 1999).

<sup>84</sup> Report of the Committee on the Elimination of Discrimination against Women, *supra* note 84, §6.

<sup>85</sup> *Id.* at § 9.

highlighted the unequal power relationship between men and women in the home and in the workplace, which may negatively affect women's health. It specifically noted sexual abuse and violence against women, and cited the interconnection with other articles, particularly education.<sup>86</sup>

A decade later in 2008, the Committee issued General Recommendation 26<sup>87</sup> focusing on female migrant workers and limited to addressing those situations where women, as workers in low-paid jobs, may be at high risk of abuse and discrimination. Migrant farmworkers fell into those categories of women migrant workers who join their spouses or other members of their families who are also workers, as well as, undocumented workers. Common experiences included discrimination, xenophobia and racism, as well a lower wages than their male counterparts.<sup>88</sup> Environmental concerns were also noted for those populations working in factories or farms and subpar living conditions that may include overcrowding, the absence of running water, inadequate sanitary facilities, or lack privacy and hygiene.<sup>89</sup> The Committee reiterated its concerns of women being vulnerable to sexual abuse, sexual harassment, and physical violence and specifically noted the experience of migrant workers on farms as a worldwide problem.<sup>90</sup> In response, the Committee recommended the formulation of comprehensive gender-sensitive and rights-based policies; active involvement of migrant workers and NGOs; research, data collection, and analysis; legal protection; complaint mechanisms; access to remedies; and temporary shelters, among other measures.<sup>91</sup>

The Committee went to extensive lengths to expand upon interrelated rights and their effects on health, yet the non-binding nature of general recommendations raises issues concerning the authoritative adjudicator on questions of interpretation. At first blush, this may suggest an inquiry into the precise scope of interpretation. This kind of inquiry is not, in practice, so much a theoretical exercise in determining what the law is, but rather who says what it is. Gardiner cites the potential role of international organizations of general interpretative competence, such as international courts, tribunals, and national legal systems, among the most preeminent bodies.<sup>92</sup> Consider the issue of whether Art. 12 of CEDAW condones the provision of, and access to, abortions. I have argued elsewhere that this is somewhat of a moot point because the CEDAW Committee has already recommended access to therapeutic abortions to numerous States Parties in their deliberations upon States Parties' compliance with the treaty obligations.<sup>93</sup> A dis-

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<sup>86</sup> *Id.* at §§ 12-13.

<sup>87</sup> General Recommendation No. 26 on Women Migrant Workers, CEDAW Res. C/2009/WP.1/R (Dec. 5, 2008).

<sup>88</sup> *Id.* at § 14.

<sup>89</sup> *Id.* at § 17.

<sup>90</sup> *Id.* at § 20.

<sup>91</sup> *Id.* at § 23.

<sup>92</sup> RICHARD GARDINER, *TREATY INTERPRETATION* 111-38 (Oxford U. Press 2008).

<sup>93</sup> Dhrubajyoti Bhattacharya, *The Perils of Simultaneous Adjudication and Consultation: Using the Optional Protocol to CEDAW to Secure Women's Health*, 31 *WOMEN'S RTS. L. REP.* 42 (2009).

tinct, but related, issue is to what extent an individual party may seek solace in invoking a right to seek out relief vis-à-vis a General Recommendation. There cannot be relief without a claimant, and neither the treaty nor the General Recommendations engender the urgency of procedural safeguards. The journey of perfecting an imperfect right through issuing general recommendations, engaging in treaty interpretation, and awarding relief to affected parties, are futile if the affected party cannot bring the claim forward. This is readily accomplished by ratifying an Optional Protocol, but will necessarily raise issues of State sovereignty and to what extent a State will engage an international tribunal to influence its domestic policy. As indicated, above, the absence of guidance on best practices is not, however, for lack of trying on the part of treaty monitoring bodies.

*WHA Resolution 61.17*

That same year (2008), the Sixty-First World Health Assembly issued a resolution on the health of migrants.<sup>94</sup> Unlike General Recommendation 26, discussed above, the resolution was a broader appeal to universal measures of monitoring and responding to the unmet health needs of migrants generally. The resolution did recommend the development of policies sensitive to the specific health needs of men, women, and children; and the promotion of equitable access to services without discrimination on the basis of gender. Still, the measure was neither intended nor capable of addressing the sex-specific issues affecting female migrant workers. Nonetheless, its issuance was consistent with a broader movement within the international law community to recognize the unmet health needs of migrants as a priority for health and human rights advocates.

B. U.S. Federal Law on Migrant Workers and Private Rights of Action

When we turn to domestic laws on migrant workers, particularly those employed within the agricultural industry, the relevance and value of international law becomes readily apparent. At the federal level, we have the Federal Migrant and Seasonal Agricultural Worker Protection Act<sup>95</sup> (AWPA) and the Victims of Trafficking and Violence Prevention Act. We will examine these statutes to review the scope of the health-related provisions and reporting mechanisms, particularly with respect to incidents of assault or sexual harassment.

*Migrant and Seasonal Agricultural Worker Protection Act*

Section 203(b)(1) of the AWPA requires certification by a state or local health authority or other agency to ensure satisfaction of applicable safety and health standards for occupancy by migrants for residential purposes.<sup>96</sup> As such, we do find that the local health department has a potential interest in structural safety

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<sup>94</sup> World Health Assembly, *Health of Migrants*, WHA 61.17 (May 24, 2008).

<sup>95</sup> 29 U.S.C. § 1801 (1983).

<sup>96</sup> 29 U.S.C. § 203(b)(1) (1983).

and its health implications. Additionally, under Section 401(b)(2)(B), the act requires, “consistent with the protection of the health and safety of migrant,” compliance with standards of motor vehicle safety as prescribed by regulations issued by the Secretary of Labor for transport of migrants to or from the place of work.<sup>97</sup> These provisions suggest that health promotion under the AWPA is thereby narrowly tied to measures of physical safety in the transportation of, and dwellings for, migrants. Relief is also available through a private cause of action related to these explicit provisions. For matters of abuse or harassment, however, the Victims of Trafficking and Violence Protection Act of 2000 provides a seemingly attractive avenue of redress.

### *Victims of Trafficking and Violence Protection Act of 2000*

As indicated in Part I, by some estimates, over 80% of female migrant workers may have experienced sexual harassment, and this percentage increases to 97% within our sample from California. Fear of being harassed, deported, or subject to other measures stemming from an individual’s legal status may potentially deter some victims from reporting incidents to law enforcement. This act enables the acquisition of a U-Visa to protect undocumented immigrants by creating temporary legal status to victims if they have suffered substantial physical or mental abuse and cooperate with the investigation.

Eligibility requires, under Section 101(a)(15)(U), a showing of “substantial physical or mental abuse,” and of course, compliance by law enforcement to investigate the complaint and document the abuse.<sup>98</sup> Moreover, law enforcement must certify that the alien “has been helpful, is being helpful, or is likely to be helpful” in the investigation or prosecution of criminal activity described in Section 101(a)(15)(U)(iii).<sup>99</sup> It is unclear how many victims would avail themselves of this avenue of relief given the potential uncertainty of meeting the threshold of demonstrating “substantial” physical or mental abuse, the willingness of law enforcement to investigate a claim, and the lag time in acquiring certification of cooperation.

Consequently, what we might glean from this cursory review is a narrow scope of health as it relates to the migrants and limited protections or avenues of redress when it comes to potential violations of rights that have health-related consequences, including physical and mental abuse or harassment.

### **III. Drafting a Local CEDAW Ordinance for Female Migrant Workers**

While we know that CEDAW, its general recommendations, and even a broad WHA resolution may help overcome those shortcomings, the U.S. has not ratified the Convention, notwithstanding becoming a signatory to the treaty and mul-

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<sup>97</sup> 29 U.S.C. § 401(b)(2)(B) (1983).

<sup>98</sup> The *Victims of Trafficking and Violence Protection Act of 2000*, Pub. L. No. 106-386, § 1513(b)(3)(U)(i)(I) (2000)(amending Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(as amended by Section 107 of the act)).

<sup>99</sup> *Id.* at 1513(b)(3)(U)(iii).

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multiple Senate committee hearings on the same. This seemingly bleak picture does not conclude our analysis. Indeed, this is where the value of international law must not be restricted to formal obligations that States adopt at the international level. Ironically, it was a U.S. city ordinance that illustrates the potential to advance the application of a health and human rights approach to this particular community.

### A. Precedent for Effectiveness: San Francisco CEDAW Ordinance

In 1997, the City of San Francisco passed an ordinance inspired by CEDAW to reduce sex discrimination and increase gender equity as relates to health, safety, and employment. In addition to making explicit the healthcare mandate of Art. 12 of CEDAW, the ordinance included two additional components that were lacking in the original treaty. First, it afforded definitional clarity and articulated an explicit method to address sex discrimination. Specifically, it defined “gender equity” as redress of discriminatory practices and establishment of conditions enabling women to achieve full equality with men, recognizing that needs of women and men may differ, resulting in fair and equitable outcomes for both. Moreover, it required a “gender analysis” as an examination of the cultural, economic, social, civil, legal and political relations between women and men within a certain entity. Notably, the recognition of those different components is consistent with a framework that incorporates social elements, and requires an interdisciplinary approach to effectively improve public health.

Beyond this framework, the specific measures incorporated elements that recognized the interdependence of rights to secure health, safety, and employment. Specifically, the ordinance required measures to (1) eliminate discrimination against women and girls in the City of San Francisco in employment and other economic opportunities, (2) to prevent and redress sexual and domestic violence, and (3) eliminate discrimination in the field of healthcare. Employment protections included: right to equal remuneration, health and safety in the workplace, including protection from violent acts at the workplace. The provision on violence was specifically geared towards vulnerable populations that would otherwise be reluctant or historically unable to engage law enforcement without fear of repercussions. The ordinance specifically mentions prostitutes as a population whose “legal status” tends to marginalize them and noted that it would be the goal of the City to develop and fund projects to assist those individuals who were victims of violence. The healthcare provisions were also a mirror image of Art. 12 of CEDAW.

### B. Recommendations for Surveillance, Monitoring, and Intervention

There are a number of lessons that can be drawn from the San Francisco ordinance that could be applicable to migrants, and specifically farmworkers. First, it affords a robust package of protections across numerous spheres that affect health, namely, employment, access to care, and personal safety in the home and workplace. Beyond legislative reform that promotes access to care, the dual provision of safety and freedom from harassment in the home and workplace, and



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accountability, become critical measures that would yield measurable health effects. It also provides enhanced protection for vulnerable populations without predicating redress upon legal status, which may exacerbate health disparities within this population owing to their potential reluctance to engage law enforcement, or otherwise draw attention to the perpetrators.

After documenting the findings from the gender analysis, the entity must adopt a concrete action plan to institute corrective measures. Under Section 4.K.12(b), the entity “shall develop an Action Plan that contains specific recommendations on how it will correct any identified deficiencies. . .” In this way, the ordinance secures two fundamental aspects of public health, namely, surveillance and monitoring, and intervention. It will not do to simply take an accounting of risk factors, and relegate the necessary remedial measures to an indeterminable future. Accountability is an essential component of the ordinance and is categorically imperative to secure the health and well-being of the affected individuals. In addition to general measures of accountability, a deterrent effect through fines or penalties associated with noncompliance would secure gaps that are otherwise corrected by formal ratification of the treaty and related measures.<sup>100</sup>

### IV. Conclusion

Social determinants compel us to think of health as a social construct. In doing so, we are no longer limited in our choice of interventions. Specifically, we must move beyond a strictly medical model to treat ill health as an aberration from normal as defined by a medical diagnosis; but rather, identify and engage those root causes or determinants that are further upstream. The implications of incorporating social epidemiological profiles frameworks within health and human rights assessments are profound and make us realize that health is intertwined with other areas that often fall outside the purview of a health department, especially when it comes to education and development. Against a backdrop of political, legal, social, and fiscal constraints, it is imperative that as practitioners, we identify short- and long-term goals and recognize the work before us as part of a process that will implicate many public and private stakeholders. However, if we adopt a broader view of health, we will have already made progress and recognize that public health is truly what we, as a society, do to assure those conditions that secure population health. Incorporating a social epidemiological framework into formal health and human rights assessments would constitute a robust legal framework and guide best practices for stakeholders, including government (and specifically health) officials, law enforcement, women, and healthcare providers.

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<sup>100</sup> CEDAW, *supra* note 80, art. 29 (requiring arbitration within six months for disputes arising among States Parties or subsequently refer the issue to the International Court of Justice). The treaty does not empower individuals to bring claims against their States for noncompliance with treaty obligations. Claims can be brought by citizens of States that have ratified the treaty’s Optional Protocol, but this avenue of redress will be unavailable until the treaty has initially been ratified. Until the political landscape is amenable to ratification of the treaty, these proposed measures may afford some temporary relief to affected parties.