

## Part 7: Equity

### Article X1 Non-discrimination

(a): States shall ensure the right to health and all of its elements as contained in the Convention and its protocols [, and those rights as described in other international treaties {and other instruments} required to enable people to achieve the highest attainable standard of health], including with respect to both health and non-health sector laws, policies, and practices, without discrimination based on racial or ethnic identity, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

(b) Prohibited discrimination based on other status includes but is not limited to discrimination based on indigenous status, physical or mental disability, nationality, sexual orientation, gender identity, marital or family status, actual or perceived health status, age, place of residence, imprisonment or other confinement, citizenship status, immigration status including undocumented immigrants or irregular migration status, statelessness, or economic or social situation, including poverty or homelessness.

(c) Prohibited discrimination ???against women??? includes failing to provide health services specific to or disproportionately required by women, including but not limited to sexual and reproductive health services.

(d) Both intentional and unintentional discrimination is prohibited both with respect to direct (formal) and indirect (substantive) discrimination, as is discrimination based on an individual's association with a person or group of a particular status.

(i) Direct (formal) discrimination refers to laws, policies, or practices that treat a person or group unfavorably based on any prohibited grounds.

(ii) Indirect (substantive) discrimination refers to laws, policies, or practices that appear neutral but have a disproportionate negative impact on members of a group that is defined by any the prohibited grounds.

(e) Each state shall review its laws, regulations, policies, and enforcement practices to identify any forms of discrimination prohibited under this Article, and within X years of this Convention coming into force for that state, shall reform such laws, regulations, policies, and enforcement practices to bring them into compliance with this Article.

### Article X2 Health equity

(a) States shall take all necessary measures, to the maximum of their available resources, to progressively achieve health equity, as defined in Article 1 of this Convention [NOTE: Still to be drafted], as expeditiously as possible.

### Article X3 Health equity programs of action

(a) States shall, through highly inclusive processes, develop national-level comprehensive health equity programs of action to develop a multi-sector actionable strategy to progress towards achieving health equity.

(b) Health equity programs of action should/shall:

(i) Be developed through participatory approaches that aims to empower members of marginalized and disadvantaged populations, including by ensuring their participation in the leadership of any committees, commissions, or other structured developed as part of or that contribute to developing the program of action;

(ii) Address structural impediments, including root causes of discrimination and marginalization, the underlie health inequities.

(iii) Be multi[inter]sectoral, systematically addressing the social (including cultural), environment, economic (including commercial), and political determinants of health that affect health equity;

(iv) Systemically address each population disadvantaged by [experiencing] health inequities; [OR: Systematically address each marginalized and disadvantaged population]

(v) Include specific actions, targets, and timelines for achieving those targets;

(vi) Incorporate a comprehensive strategy for accountability that includes

(1) monitoring, evaluation, and analysis of reasons for any missed benchmarks and targets or other indications of lack of progress, along with a strategy and actions to respond to shortcomings;

(2) opportunities for the public, including members of marginalized and disadvantaged populations, to engage with policymakers on implementation of the health equity program of action;

(3) ongoing mechanisms that include civil society and members of marginalized and disadvantaged populations to monitor and report on the health equity program of action

(4) actions to strengthen disaggregated collection and use, as needed;

(5) capacity building activities as required to more effectively implement the health equity program of action;

(6) accountability mechanisms at the national, community, and other sub-national levels, such as those delineated in Section/Article X [NOTE: Still to be drafted], to ensure implementation of the health equity program of action.

(c) To accompany or as part of health equity programs of action, states should/shall develop and implement a strategy for research, as needed, to enhance understanding and more effectively respond to health inequities.

(d) States should/shall develop such processes and structures as needed to ensure sustained high-level political attention to health equity.

(e) States should considered developing health equity programs of action at sub-national levels.

(f) Each state shall complete development of and begin to implement a national health equity program of action not more than two [three] years after this Convention enters into force for that state.

(g) States shall periodically update health equity programs of action, giving strong consideration to updating them not less frequently than once every five years.

(h) The Secretariat should develop guidance to assist states in developing and implementing health equity programs of action.

#### Article X4 Equitable distribution of resources

- a. States shall assess how health funding, health workers, health facilities, and health services...are distributed equitably across different geographic areas, such as districts (counties) and states (provinces) and populations, including rural and urban areas, populations or regions of different income (wealth) and poverty levels, and other metrics based on national context, which may include race, ethnicity, indigenous status, religion, or national origin.
- b. Based on this analysis, states shall develop a strategy with a time-bound action plan to achieve the equitable distribution of health funding, health workers, health facilities, and health services financial, human, and other health resources where disparities exist.
- c. States shall, as needed to contribute to equitable access to health services and equitable health outcomes, provide extra financial, human, and other resources as appropriate to areas with higher levels of poor health outcomes or [and] lower access to quality health services.
- d. The strategy referred to in section (b) of this article shall be developed with the full and meaningful participation of civil society and community members, including with measures to enable full participation of people in regions or belonging to populations that have poorer health outcomes, reduced access to quality health services, and/or fewer health resources.

Article X5 Where migrants do not intend to make the state their domicile, the state of their current residence shall ensure migrants the right to health without discrimination. [The state of their citizenship should, where possible, contribute to the costs of their health care, based on bilateral agreements with the state of their current residence.]

#### Article X6 Disaggregated data

- a. States shall develop systems to collect and utilize data on health service coverage, including for health care and underlying determinants of health, and health outcomes, based on income, sex, [gender,] age, race, ethnicity, migratory status, disability, geographic location, and other characteristics relevant in national contexts.
- b. States should incorporate the categories listed in section (a), where possible, with respect to data on social determinants of health.
- c. States shall, following and based on the input from a public consultative process, define and submit to the Secretariat the “characteristics relevant in national contexts” for which they will disaggregate data[, as well as a description of the consultative process and summary of the public input].

- d. States shall develop these systems within X years of this Convention coming into force in that state.
  - i. If a state does not expect to be able to meet this deadline, it will inform the Secretariat as soon as such a concern arises, and the Secretariat and state will work to develop a revised timeline, as well as to ensure the state any necessary technical and financial assistance to develop the system of disaggregated data collection and use.
- e. State shall develop safeguards to ensure that the processes of collecting and using disaggregated data to not create any risk to individuals' privacy or the confidentiality of personal information.

Article X7 International assistance and cooperation for health equity

- a. In their international health assistance and cooperation, States shall prioritize support for marginalized and disadvantaged populations, including to support countries in developing systems for disaggregated data as described in Article X6.
- b. States shall take proactive measures to ensure that in countries to which they are providing international health-related assistance, members of marginalized and disadvantaged populations have meaningful and ongoing opportunities to provide input into the use of that assistance, including in related monitoring and evaluation.
- c. If members of marginalized and disadvantaged populations express concerns related to international health assistance[,in particular with respect to its success in contributing to health equity as well as their ability to effectively and meaningfully engage in decision-making with respect to that assistance,] States providing the assistance shall work with these populations to develop and implement strategies to effectively respond to these concerns.