

Abstract

In April 2002, the United Nations (UN) Commission on Human Rights established a new “special procedure”—the UN Special Rapporteur on the right to health, to which the author was appointed in September 2002. It is in this capacity that the author has written this first-person commentary, in which he sets out his vision for the key objectives, themes, and interventions to be pursued over the course of his mandate. Included here are his three primary objectives—to promote and encourage others to promote the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to identify good practices for operationalizing the right to health at the community, national, and international levels—and the ways they should be approached.

En avril 2002, la Commission des Nations Unies (ONU) pour les droits humains a établi une nouvelle «procédure spéciale» — le Rapporteur Spécial des Nations Unies sur le droit à la santé, poste auquel l’auteur a été nommé en septembre 2002. C’est à ce titre que l’auteur a écrit ce commentaire à la première personne, commentaire dans lequel il précise sa vision sur les principaux objectifs, thèmes et interventions à développer au cours de son mandat. On trouvera ici ses trois objectifs essentiels — promouvoir, et encourager d’autres personnes à promouvoir, le droit à la santé comme droit humain fondamental ; éclaircir les contours et le contenu du droit à la santé ; et identifier de bonnes pratiques pour rendre concret le droit à la santé à tous les niveaux (local, national et international) — ainsi que les façons dont ils doivent être abordés.

En abril de 2002, la Comisión de Derechos Humanos de las Naciones Unidas (ONU) estableció un “procedimiento especial” nuevo: el Relator Especial de la ONU sobre el derecho a la salud, al cual el autor fue designado en septiembre de 2002. Es en tal capacidad que el autor ha escrito este comentario en primera persona, en el cual expone su visión para los objetivos, temas e intervenciones clave a procurar en el transcurso de su mandato. Allí se incluyen sus tres objetivos primarios, y las formas en que se deben abordar: impulsar y alentar a otros a promover el derecho a la salud como humano fundamental; aclarar los contornos y el contenido del derecho a la salud; y identificar prácticas positivas para poner en operación el derecho a la salud a niveles comunitario, nacional e internacional.

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THE UN SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH: Key Objectives, Themes, and Interventions

Paul Hunt

The United Nations (UN) has developed two types of human rights monitoring mechanisms: those established under human rights treaties and those set up by the UN Commission on Human Rights. The mechanisms established by the Commission are often referred to as “special procedures.” Some are country-specific and others are thematic. The first wave of thematic special procedures addressed classic civil and political rights issues, such as disappearances (1980), summary executions (1982), torture (1985), and religious intolerance (1986).¹⁻⁴ Following the 1993 World Conference on Human Rights, however, the Commission has shown an increased willingness to establish special procedures on economic, social, and cultural rights.⁵ Thus, it established Special Rapporteurs on the rights to education (1998), housing (2000), food (2000), and, most recently, health (2002).⁶⁻⁹

A nongovernmental campaign to establish a Special Rapporteur on health issues first gained momentum in the mid-1990s. The original proposal was for a special procedure

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on the need to protect the independence and integrity of health professionals, similar to human rights procedures that protect judges and lawyers. But more recently the proposal was expanded to encompass the promotion and protection of the right to health.

Crucially, in April 2002, the Brazilian government urged the Commission to establish a Special Rapporteur on the right to health. After protracted negotiations, the Commission adopted and unanimously approved the Brazilian resolution.¹⁰ As the proposal worked its way through the UN system, the United States and Australia voted against the initiative. Nonetheless, the new special procedure on “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” was established.¹¹

Responsibilities and Obligations of the Special Rapporteur

In September 2002, I was appointed Special Rapporteur by the Chairperson of the Commission. Although nominated by New Zealand, I serve in my personal capacity as an independent expert. As Special Rapporteur, I am requested to do the following:

- Gather, request, receive, and exchange right to health information from all relevant sources.
- Dialogue and discuss possible areas of cooperation with all relevant actors, including governments; UN bodies; specialized agencies and programs, in particular the World Health Organization (WHO) and the Joint UN Program on HIV/AIDS, as well as nongovernmental organizations (NGOs); and international financial institutions.
- Report on the status of the realization of the right to health throughout the world, including laws, policies, good practices, and obstacles.
- Make recommendations on appropriate measures to promote and protect the right to health.¹²

The Special Rapporteur is also mandated to apply a gen-

der perspective, to pay special attention to the needs of children in the realization of the right to health, to take into account the relevant provisions of the Durban Declaration and Program of Action, and to bear in mind, in particular, General Comment No. 14 of the Committee on Economic, Social, and Cultural Rights (CESCR) and General Recommendation No. 24 of the Committee on the Elimination of Discrimination against Women (CEDAW).^{13,14}

A few months after my appointment, I presented my preliminary report to the UN Commission on Human Rights. Because space does not permit an in-depth examination of the content of that report, I have chosen to focus here on some of the key objectives, themes, and interventions arising from the contemporary realization of the right to health. The full report, which includes an examination of the sources, contours, and content of the right to health, can be read in its entirety on the UN Commission on Human Rights web site.^{15,16} I would like to emphasize briefly four crucial jurisprudential elements of the right to health that inform this discussion.

First, the right to health includes, but goes beyond, the right to health care: The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including information on sexual and reproductive health.¹⁷

Second, 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 nonconsensual medical treatment and experimentation. Entitlements include the right to a system of health protection (i.e., health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.¹⁸

Third, the right to health imposes some immediate obligations: Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect. These immediate obliga-

tions include the guarantees of nondiscrimination and equal treatment, as well as the obligation to take deliberate, concrete, and targeted steps toward the full realization of the right to health, such as the preparation of a national public health strategy and plan of action. Progressive realization means that states have a specific and continuing obligation to move as expeditiously and effectively as possible toward the full realization of the right to health.¹⁹

Fourth, the right to health gives rise to responsibilities in relation to international assistance and cooperation: States have an obligation to take steps, individually and through international assistance and cooperation, toward the full realization of the right to health. For example, states are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy has an adverse impact on the right to health, and to make certain that their representatives in international organizations take due account of the right to health, as well as the obligation of international assistance and cooperation, in all policymaking matters.²⁰

Broad Objectives

Given the state of the right to health today, three broad interrelated objectives deserve particular attention:

1. *To promote—and to encourage others to promote—the right to health as a fundamental human right, as set out in numerous legally binding international human rights treaties, resolutions of the Commission on Human Rights, and the Constitution of the WHO.* Although the right to health is a fundamental human right that has the same international legal status as freedom of religion or the right to a fair trial, it is not as widely recognized as these and other civil and political rights. Many different actors, such as governments, international organizations, and civil-society groups, can help to raise the profile of the right to health as a fundamental human right. While it may take some years before the right to health enjoys the same currency as other, more-established human rights, a crucial goal should be to ensure that the right to health receives widespread

recognition as a fundamental human right.

2. *To clarify the contours and content of the right to health in jurisprudential terms. What does the right to health mean? What obligations does it give rise to?* Although national and international jurisprudence on the right to health is growing, the legal content of the right is not yet well established.²¹ This is not surprising, given the historic neglect of the right to health, as well as other economic, social, and cultural rights. Thus, a second key objective is to clarify and explore the contours and content of the right to health by drawing first on the evolving national and international jurisprudence and second on the basic principles that animate international human rights law, such as equality, nondiscrimination, and dignity of the individual.

3. *To identify good practices for operationalizing the right to health at the community, national, and international levels.* Once human rights are recognized and their legal content understood, their legal provisions must be operationalized. In other words, national and international norms must be translated into effective policies, programs, and projects. How to go about such a transition for the right to health is not readily evident, any more than it is for a number of other human rights. Fortunately, different jurisdictions can provide examples of good laws, policies, programs, and projects that reflect the right to health. While what works in one context might not necessarily work in another, lessons can be learned. Thus, collecting, analyzing, and promoting good practices on the right to health are important steps. These good practices may be found at the community, national, and international levels and may be related to various actors including governments, courts, national human rights institutions, health professionals, civil-society organizations, and international organizations.

Main Themes

The right to health extends across a wide, diverse, and at times highly complex range of issues. To make promoting the right to health more manageable, I suggest focusing on two interrelated themes. As Special Rapporteur, I will not confine myself exclusively to them, but I propose, broadly

speaking, to organize the mandate around the twin themes of poverty and the right to health and discrimination, stigma, and the right to health.

As affirmed in the UN Millennium Declaration, poverty eradication has become one of the key, overarching policy objectives of the UN, as well as of other international organizations and many states.²² Discrimination and stigma both continue to seriously constrain and undermine progress in the field of health. The themes of poverty, discrimination, and stigma especially affect issues of gender, children, and racial discrimination. These themes also lend themselves to an examination of other important issues, such as those relating to mental health and HIV/AIDS.

Poverty and the Right to Health

The right to health has a significant and constructive role to play in poverty reduction and related strategies. Policies based on national and international human rights are more likely to be effective, sustainable, inclusive, equitable, and meaningful for those living in poverty.²³

Health and Poverty²⁴

Ill-health destroys livelihoods, reduces worker productivity, lowers educational achievement, and limits opportunities—all of which can contribute to poverty. Conversely, poverty can diminish people's access to medical care, increase exposure to environmental risks, contribute to the worst forms of child labor, and cause malnutrition—all of which can predispose people to ill-health. In other words, ill-health is both a cause and a consequence of poverty: Sick people are more likely to become poor, and the poor are more vulnerable to disease and disability.

Good health is central to creating and sustaining the capabilities that poor people need to escape from poverty. Good health is a key asset for the poor and can contribute to improving their economic security. Good health is not just an outcome of development; it is a way of achieving development. It is for this reason that health issues are prominent in the UN Millennium Declaration and the Millennium Development Goals.²⁵

Millennium Development Goals: The Prominence of Health

Of the eight Millennium Development Goals (MDGs), four are related to health: (a) by the year 2015, to reduce maternal mortality by three-quarters its current rate; (b) by 2015, to reduce mortality of children younger than five years by two-thirds its current rate; (c) by 2015, to halt and begin to reversing the spread of HIV/AIDS, malaria, and other major diseases that afflict humanity; and (d) to ensure environmental sustainability.

Elements of the other MDGs—in particular a global partnership for development—also bear closely on the right to health. Further, eight of the 16 MDG “targets” and 17 of the 48 MDG “indicators” are health related.

Given the prominence of health in the MDGs and in their “targets” and “indicators,” it is important to examine the health-related MDGs through the prism of the right to health.

MDGs and the Right to Health

The MDGs are not framed in terms of human rights. In fact, when looking at them from a human rights perspective, three particular objections may be made.

First, the health-related MDGs are incomplete: They do not address crucial health issues that are essential features of the right to health. For example, they make no reference to reproductive health. This omission is especially striking in that the outcomes of both the Cairo and Beijing conferences, as well as the International Development Targets (forerunner of the MDGs), have explicitly included reproductive health.²⁶⁻²⁸ Responses countering such criticism have emphasized that the MDGs are not intended to be comprehensive, pointing out that there are crucial health-related goals and targets that fall outside the parameters of the MDGs and that the MDGs should be complemented and supplemented. Nevertheless, reproductive health is certainly an integral element of the right to health and must be incorporated in any strategy reflective of the right to health.

Second, from a human rights perspective, the average condition of an entire population is unhelpful and can even be misleading: Focusing only on average health indicators

may actually mask conditions within vulnerable groups. Thus, human rights require that all relevant data be disaggregated to accurately capture conditions of specifically disadvantaged groups—including poor women, minorities, indigenous peoples, and the like. The health-related MDGs, however, are not disaggregated. One contribution that the right to health can make to the health-related MDGs is to insist on appropriate disaggregation to help identify policies and programs that will deliver the promise of the Millennium Declaration to all individuals and groups.

Third, it might be argued that, from a human rights perspective, the goal of reducing maternal mortality by three-quarters by 2015 is unacceptable; it must instead be to eliminate *all avoidable* maternal mortality. The concept of progressive realization, which is an integral feature of many human rights, including the right to health, does not make the unreasonable demand that all human rights must be realized overnight. Progressive realization recognizes present realities, including resource constraints, and allows for the realization of the right to health over a period of time.

Crucially, however, a human rights approach imposes conditions on the conduct of progressive realization—otherwise progressive realization can remove substance from human rights and turn them into mere rhetoric. A human rights approach demands that a state take all measures in its power to move as expeditiously and effectively as possible toward the full realization of the right to health. Also, a human rights approach demands that minimum essential levels—or core obligations—of the right to health should always be respected. Criteria such as these ensure that the concept of progressive realization is not abused. They also explain why effective, transparent, and accessible monitoring and accountability arrangements are essential features of a human rights approach.

Thus, an MDG to reduce maternal mortality by three-quarters by 2015 would certainly be unacceptable from a human rights perspective if that were the ultimate goal, rather than the intermediate goal that it is. Given the concept of progressive realization, there is no human rights objection in principle to the maternal mortality MDG.

However, whether this MDG—and measures taken to reach it—is consistent in practice with international human rights law is a different and crucial question that can be answered only after carefully examining relevant law, policy, and practice.

In conclusion, the UN Secretary-General's roadmap for implementing the UN Millennium Declaration also encourages consideration of the health-related MDGs through the prism of the right to health. According to this roadmap, "economic, social and cultural rights are at the heart of all the Millennium Development Goals."²⁹ Thus, examining a selection of periodic MDG country-level reports from the perspective of the right to health, with a view to suggesting ways in which the health component might more effectively benefit the poor and reduce poverty, is appropriate.

Poverty, Human Rights, and the Right to Health

A growing body of literature and practice has emerged that focuses on the impact of human rights on poverty reduction.³⁰ In brief, human rights empower the poor; help tackle discrimination and inequality; require the participation of the poor; underscore the importance of all rights in the struggle against poverty; render some policy choices (e.g., those with a disproportionately harmful impact on the poor) impermissible; emphasize the crucial role of international assistance and cooperation; and introduce the notion of obligation and thus the requirement of effective, transparent, and accessible mechanisms of accountability.

Less literature and practice exist on the contribution that the right to health specifically has made to poverty reduction—and it is this issue that demands particular attention. A poverty-reduction strategy based on the right to health would, for example, focus on improving poor populations' access to health services by, perhaps, identifying diseases that are particularly prevalent among the poor and creating immunization and other programs that are specifically designed to reach the poor; improving the effectiveness of public health interventions by, for instance, implementing basic environmental controls, especially for waste disposal

in areas populated by the poor; reducing the financial burden of health protection on the poor, e.g., by reducing or eliminating user fees for the poor; and promoting policies in other sectors that bear positively on the underlying determinants of health, e.g., supporting agricultural policies that have positive health outcomes for the poor.

Ultimately, exploring the specific contribution the right to health makes to reducing poverty is important. This contribution has to be understood in the overall context of the contributions human rights—including nondiscrimination, participation, international cooperation, and accountability—make to reducing poverty.

Discrimination and Stigma and the Right to Health

Discrimination and stigma is a second key theme relevant to the right to health. Discrimination on the grounds of gender, race, ethnicity, and other factors is a social determinant of health. Social inequalities, fuelled by discrimination and marginalization of particular groups, shape both the distribution of diseases and the course of health outcomes among those afflicted. As a result, the burden of ill-health is borne by vulnerable and marginalized groups in society. At the same time, discrimination and stigma associated with particular health conditions, such as mental disorders, and diseases, such as HIV/AIDS, tend to reinforce existing social divisions and inequalities.

Nondiscrimination is among the most fundamental principles of international human rights law. The International Covenant on Economic, Social and Cultural Rights (ICESCR) proscribes

any discrimination in access to health care and underlying determinants of health, as well as to 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, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.³¹

As well as prohibiting discrimination on a range of

specified grounds, such as race, color, sex, and religion, international human rights instruments also prohibit discrimination on the grounds of “other status.” The Commission on Human Rights has interpreted this term to include health status.³² Thus, the Commission and CESCR agree that states have an obligation to take measures against discrimination based on health status, as well as in relation to other prohibited grounds. With respect to the right to health, states have an obligation to ensure that health facilities, goods and services—including the underlying determinants of health—are accessible to all, especially the most vulnerable or marginalized sectors of the population, without discrimination.³³

The links between stigma, discrimination, and denial of the right to enjoy the highest attainable standard of health are complex and multifaceted. Together, discrimination and stigma amount to a failure to respect human dignity and equality by devaluing those affected, often adding to the inequalities already experienced by vulnerable and marginalized groups. This increases people’s vulnerability to ill-health and hampers effective health interventions. The impact is compounded when an individual suffers double or multiple forms of discrimination based, for example, on gender, race, poverty, and health status.

Effectively promoting the right to health requires identifying and analyzing the complex ways in which discrimination and stigma have an impact on the enjoyment of the right to health of those affected, particularly women, children, and marginalized groups, such as racial and ethnic minorities, indigenous peoples, persons with disabilities, People Living with HIV/AIDS, refugees, the internally displaced, and migrants. Promoting the right to health also requires gathering and analyzing data to better understand how various forms of discrimination are determinants of health, recognizing the compounding effects of multiple forms of discrimination, and documenting how discrimination and intolerance affect health and access to health care services. It will also require carefully balancing the need to address discrimination and stigma in relation to health by encouraging the disaggregation of data and the development of policies and strategies to combat discrimination, while

also ensuring that publication of such data does not perpetuate stigma. The impact of stigma and discrimination on the enjoyment of the right to health is best understood in relation to particular populations, such as women, racial and ethnic minorities, people with disabilities, and People Living with HIV/AIDS.

Women

Systematic discrimination based on gender impedes women's access to health and hampers their ability to respond to the consequences of ill-health for themselves and their families. Factors that increase women's vulnerability to ill-health include insufficient access to the information, education, and services needed to ensure sexual and reproductive health; an inability to defend themselves against violence, including sexual violence, and against harmful traditional practices; and lack of legal capacity and equality in family matters.³⁴ States have an obligation to ensure that both men and women have equal access to the enjoyment of all rights, including those that ensure equality and nondiscrimination in areas such as political rights, marriage and family, employment, and health.

Racial and Ethnic Minorities

Racism, racial discrimination, and related intolerance contribute to inequalities in health and health care of ethnic and racial groups.³⁵ The International Convention on the Elimination of All Forms of Racial Discrimination requires states to prohibit and to eliminate racial discrimination and to guarantee the right of everyone, without distinction on the basis of race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of the right to health and medical care.³⁶ At the World Conference against Racism, governments identified the need to recognize racism as a significant social determinant of health and of access to health care.³⁷ They committed to enhancing measures to fulfill the right of everyone to the highest attainable standard of health, with a view to eliminating disparities in health status that might result from racial discrimination. They also agreed to a range of relevant measures—from preventing the use of genetic research for discriminatory pur-

poses to tackling discrimination in health systems.³⁸

People Living with Disabilities

People living with disabilities, including mental disabilities, are exposed to various forms of discrimination and social exclusion that prevent them from exercising their rights and freedoms and from participating fully in their societies.³⁹ The discrimination they may be subject to ranges from denial of health services, employment, and educational opportunities, to exclusion and isolation resulting from physical and social barriers. Women with disabilities may be particularly vulnerable and are more likely to suffer from discrimination than able-bodied women or men with disabilities.

People Living with HIV/AIDS

Stigma and discrimination associated with HIV/AIDS builds on and reinforces prejudices related to gender, poverty, sexuality, race, and other factors. Fears about illness and death; the association of HIV with sex workers, men having sex with men, and injecting-drug use; and judgements about the behavior of People Living with HIV/AIDS all contribute to the impact of stigma and give rise to intolerance and discrimination.⁴⁰ Stigma and discrimination against People Living with HIV/AIDS affects the spread and impact of the disease in several crucial ways. For example, fear of being stigmatized stops people from voluntarily seeking HIV/AIDS counselling and testing, which are vital to treatment and prevention. The Declaration of Commitment on HIV/AIDS calls on states to take measures to eliminate all forms of discrimination against People Living with HIV/AIDS and members of vulnerable groups and commits states to developing strategies that combat stigma and social exclusion connected with the pandemic.⁴¹

Specific Projects, Issues, and Interventions

Given the three previously identified objectives, as well as the themes of poverty and discrimination/stigma, what are examples of specific right-to-health projects, issues, and interventions that might be usefully pursued? Below, six

possible interventions are briefly discussed that, in my opinion, deserve increased attention.⁴² Of course, many other compelling right-to-health interventions could and should be undertaken by various actors. The following illustrations are designed to signal how the general objectives and themes already identified can be taken forward and made more specific.

Poverty-Reduction Strategies

Poverty is a global phenomenon experienced in varying degrees in all nations. An increasing variety of nations—higher-income, lower-income, and those in transition—are formulating strategies to reduce poverty. Thus, one intervention is to examine a selection of poverty-reduction strategies through the prism of the right to health with a view to suggesting ways in which the health component might more effectively benefit the poor and reduce poverty.

Poverty Reduction Strategy Papers (PRSPs), derived from the Heavily Indebted Poor Countries (HIPC) initiative, are one category of antipoverty strategy. WHO recently carried out a desk review of 10 full PRSPs and three interim PRSPs. This preliminary study found little evidence of attempts to adapt national health strategies to meet the needs of the poorest populations.⁴³ Very few PRSPs have built in any health indicators that would monitor their impact on poor people or regions.⁴⁴ No PRSPs contain plans to include poor people in a participatory monitoring process.⁴⁵ All of these shortcomings would have been, at least, attenuated if the right to health had been taken into account during the formulation of the relevant PRSP. Not surprisingly, the study also found that no PRSP mentions health as a human right.⁴⁶

An examination of antipoverty strategies should not only include HIPCs and lower-income states, but should also extend to some antipoverty strategies. Moreover, the poverty-reduction strategy of a higher-income state should address two different constituencies: their own jurisdiction and developing states. In light of its obligation of international assistance, a higher-income state should consider what contribution it is making to reduce poverty in the

countries of the South. Norway, for example, has recently published *Fighting Poverty: The Norwegian Government's Action Plan for Combating Poverty in the South towards 2015*.⁴⁷ Accordingly, one project or intervention is to examine, through the prism of the right to health, higher-income states' strategies for the reduction of poverty in both their jurisdictions and in countries of the South.

Neglected Diseases

Broadly speaking, diseases fall into three categories. Type I diseases, such as hepatitis B, occur in rich and poor countries alike, with large numbers of populations vulnerable to these diseases found in each. Type II, or "neglected," diseases include HIV/AIDS and tuberculosis and are found in both rich and poor countries but are disproportionately present in poor countries.

Type III, or "very neglected," diseases, such as river blindness and sleeping sickness, overwhelmingly or exclusively plague lower-income countries. According to a recent WHO report, *Global Defence Against the Infectious Disease Threat*, the "health impact of these . . . diseases is measured by severe and permanent disabilities and deformities in almost 1 billion people. . . . Their low mortality despite high morbidity places them near the bottom of mortality tables and, in the past, they have received low priority."⁴⁸ The report continues:

[These] diseases form a group because they affect almost exclusively poor and powerless people living in rural parts of low-income countries. While they cause immense suffering and often life-long disabilities, these diseases rarely kill and therefore do not receive the attention and funding of high-mortality diseases, like AIDS, tuberculosis, and malaria. They are neglected in a second sense as well. Confined as they are to poor populations all have traditionally suffered from a lack of incentives to develop drugs and vaccines for markets that cannot pay. Where inexpensive and effective drugs exist, demand fails because of inability to pay. Neglected diseases impose an enormous economic burden in terms of lost productivity and the high costs of long-term care. . . . [These] diseases can help to guarantee that the next generation remains anchored in poverty. . . . The dis-

abilities caused by most of these diseases are associated with great stigma.⁴⁹

The lines separating these three disease categories are not rigid: Some diseases straddle two categories. Malaria, for instance, falls between types II and III.

In the case of type I diseases, incentives for research and development exist in rich countries, e.g., the market mechanism, public funding of basic research, and patent protection for product development. Products get developed, and the main policy issue for poor countries is gaining access to those technologies, which tend to be high priced and patent protected. Although many vaccines for type I diseases have been developed during the past 20 years, there is little incentive to widely introduce them into poor countries because of anticipated low returns on such an investment.

Incentives for research and development of type II diseases do exist in rich-country markets, but funding globally is not commensurate with the disease burden. A particularly accurate example of this involves vaccines for HIV/AIDS. Substantial research and development for these vaccines is underway because of rich-country market demand, but not in proportion to global need or addressed to the specific disease conditions of poor countries.

Type III diseases receive extremely little research and development, with essentially no commercial funding taking place in rich countries. Because of poverty, the market mechanism fails. Moreover, governments of poor countries lack the means to subsidize the needed research and development. Thus, research and development for diseases specific to poor countries tend to be grossly underfinanced. As the report from the WHO Commission on Macroeconomics and Health puts it: "The poor countries benefit from R&D [research and development] mainly when the rich also suffer from the same diseases."⁵⁰

The imbalance between research on diseases of the poor (type II and especially type III) and on diseases of the rich has been documented for more than a decade. In 1990, the Commission on Health Research and Development noted what has become known as the "10/90 disequilibrium:"

only 10% of research and development spending goes into health problems that affect 90% of the world's population.⁵¹ Initiatives have been launched to address this imbalance—and some progress has been made—but the initiatives remain profoundly underfunded.

Recently, neglected diseases—a problem arising from market and public-policy failures—have been given fresh impetus by a number of welcome developments, including adoption of the Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health and the work of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.⁵²

In the final analysis, particular attention must be paid to the numerous right to health implications of neglected (including very neglected) diseases and the 10/90 disequilibrium, including nondiscrimination, equality, the availability and accessibility of health facilities, goods and services (including drugs), international assistance and cooperation, and so on. Neglected diseases, very neglected diseases, and the 10/90 disequilibrium are human rights issues.

Impact Assessments

Before a state introduces a new law or policy, it has to ensure that the new initiative is consistent with its existing national and international legal obligations, including those relating to human rights.⁵³ If a state has adopted poverty reduction as a major policy objective, it must ensure that any new law or policy is consistent with that policy goal. Rigorous policymaking demands that the distributional impact of reforms on the well-being of different groups in society, especially the poor and vulnerable, is analyzed. Such an analysis has to consider—before, during, and after implementation of any relevant policy—the intended and unintended consequences of an initiative, with a view to identifying appropriate mitigating or other measures. This socially responsible impact analysis is required of states and other actors in the context of national and international policies.

Of course, there are obstacles to preparing such rigorous analyses. According to authors of a recent International

Monetary Fund (IMF) publication, these obstacles include “[d]ata limitations, weak national capacity, and a lack of donor coordination.”⁵⁴ They recommend that poverty and social-impact analyses should be strengthened and suggest the international community should do more to develop institutional capacity at the national level for the “development of alternative policy scenarios” and “the preparation of poverty and social-impact analysis.”^{55,56}

Despite these and other difficulties, different forms of impact analysis are increasingly common at the national and international levels. In Northern Ireland, new legislation requires public authorities to conduct equality-impact assessments.⁵⁷ In the context of the European Union, there is a requirement to check that some policy proposals do not have an adverse impact on health—and this has contributed to a growing literature on health-impact assessments.⁵⁸ In addition, the World Bank has recently prepared a lengthy guide, entitled *User’s Guide to Poverty and Social Impact Analysis*.⁵⁹ Some civil-society organizations have advocated the introduction of “poverty impact assessments” within the framework of the PRSP process.⁶⁰ Human rights impact assessments have been suggested for many years, most prominently in the Vienna Declaration and Program of Action, and a few actors have sought to put them into practice.^{61,62}

Appropriate impact analyses are one way of ensuring that the right to health—especially of marginalized groups, including the poor—is given due weight in all national and international policymaking processes. Accordingly, in the context of the right to health, continuing attention should be given to the different types of impact analyses with a view to identifying good practice for states and other actors.

The World Trade Organization and the Right to Health

It is not possible in a commentary of this nature and length to adequately scrutinize TRIPS and the General agreement on Trade in Services (GATS) through the prism of the right to health, an exercise begun by the former High Commissioner for Human Rights in her reports of June 2001 and 2002.^{63,64} What is clear, however, is that both agree-

ments have crucial bearings on the right to health. TRIPS, for example, affects issues of access to essential drugs and also international cooperation. As the Commission on Human Rights has observed: "Access to medication in the context of pandemics such as HIV/AIDS is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁶⁵

The Declaration on the TRIPS Agreement and Public Health, adopted at the WTO Fourth Ministerial Conference in Doha during November 2001, is a significant development.⁶⁶ The Doha Declaration recognizes "the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics."⁶⁷ The Declaration stresses that TRIPS "can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."⁶⁸ In this way, the Declaration reflects human rights perspectives, especially the right to health and the right to enjoy the benefits of scientific progress.

GATS is the first multilateral agreement governing all forms of international trade in services, including health services. Negotiations on further liberalizing trade in services are scheduled for completion by January 2005. The liberalization of trade in health services can affect the right to health in various ways, depending on a range of issues, not least of which is the regulatory environment. One issue of particular relevance is the effect increased foreign direct investment (FDI) has on the enjoyment of the right to health. While FDI can upgrade national infrastructures and introduce new technology, it can also have undesired effects where there is insufficient regulation to protect enjoyment of the right to health. For example, increased foreign private investment can lead to an overemphasis on commercial objectives at the expense of social objectives, such as the provision of quality health services for those who cannot afford commercial rates. As a recent joint study by the WTO secretariat and WHO put it: "Trade in health services, in

some cases, has exacerbated existing problems of access and equity of health services and financing, especially for poor people in developing countries."⁶⁹

In a recent resolution, the UN Commission on Human Rights called on all states

[t]o ensure that their actions as members of international organizations take due account of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and that the application of international agreements is supportive of public health policies which promote broad access to safe, effective and affordable preventive, curative and palliative pharmaceuticals and medical technologies.⁷⁰

In these circumstances, it is important to monitor and examine trade rules and policies in the context of the right to health, including implementation of the Doha Declaration.⁷¹

The Right to Mental Health

In 2001, WHO estimated that 450 million people suffered from mental or behavioral disorders and that these disorders accounted for 12% of the global burden of disease.⁷² Mental disorders, including schizophrenia, bipolar disorder, depression, mental retardation, and Alzheimer's disease and other dementias, are common in all countries. Poor and other marginalized groups tend to be disproportionately affected by these disorders in both higher-income and lower-income countries.

Most mental disorders can be managed, treated, and, in many cases, prevented. Despite this and the prevalence and impact of mental disorders, mental health has been accorded a low priority by many governments. The World Health Report 2001 observed that more than 40% of countries do not have a mental-health policy; and mental-health budgets of most countries account for less than 1% of their health expenditures.⁷³

For a majority of the world's population, mental-health care is geographically and economically inaccessible. Where it is accessible, there are significant disparities in the standards of care between and within countries. In many countries, mental-health care often consists primarily of large

psychiatric institutions that have limited provisions for community-based treatment and care.⁷⁴

A wide range of human rights violations reportedly occur in some institutions designated for the care and treatment of persons with mental disorders. These violations include torture and other cruel, inhuman, or degrading treatment, such as sexual exploitation.⁷⁵ Stigma and discrimination surround those with mental disorders, including the real or perceived incapacity of persons with mental disorders to make decisions about the treatment of their illness. It is the combination of these interrelated issues that makes persons with mental disabilities particularly vulnerable to violations of their human rights.

Thus, more attention should be devoted to this neglected element of the right to health: the right to mental health.

Health Professionals

As providers of health services, health professionals play an indispensable role in the promotion and protection of the right to health. This role, as well as the difficulties impeding their practice, must not be overlooked.

In many countries, health professionals are poorly paid, work long hours, and must make do with shortages of equipment and obsolete facilities. Poor terms and conditions of employment are a major cause of "brain drain:" the migration of medical practitioners mainly from the South to the North, but also from rural areas to urban settings within countries.⁷⁶ While the exporting countries may accrue some benefits (e.g., financial remittances from expatriates), the potential adverse outcomes, including shortages of health professionals, absence of compensation, and a decline in quality of health care, are likely to outweigh the benefits.⁷⁷ Poor terms and conditions also create incentives for better-trained medical practitioners to seek more favorable situations, often in the private sector, thereby depleting public health systems.

In some countries, professional activities have made health workers victims of discrimination, arbitrary detention, killings, and torture. These workers have also had their freedoms of opinion, speech, and movement curtailed. At particular risk are health professionals who work with vic-

tims of torture. Some health professionals have participated, often under duress, in human rights abuses, including torture and the preparation of false medical documentation to cover up human rights abuses.⁷⁸

Corruption is a problem in the provision of health services in some jurisdictions. While in some cases this problem derives from unsatisfactory employment terms and conditions, corruption in health services is not confined to health workers. Nor is it confined to one region of the world. Corruption is clearly disadvantageous to the poor and corrodes the right to health. "In many countries poor people report that they are asked to pay for medicine that should be available to them at no charge."⁷⁹ Interestingly, a recent IMF study of corruption in healthcare services concludes: "Participation of the poor in the decisions that influence the allocation of public resources would mitigate corruption possibilities."⁸⁰ Although there are no quick solutions, corruption should be understood as an issue of both poverty and the right to health.

Conclusion

International human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policymaking processes. In the context of international policymaking, this fundamental principle is reflected in the Vienna Declaration and Program of Action, as well as in the Secretary-General's reports *Renewing the United Nations: An Agenda for Reform* (1997), *Strengthening of the United Nations: An Agenda for Further Change* (2002), and *Roadmap Toward Implementation of the United Nations Millennium Declaration* (2001).⁸¹⁻⁸³ Moreover, the principle is also reflected in positions taken by the UN Commission on Human Rights, such as its resolution calling on States parties to the ICESCR to "ensure that the Covenant is taken into account in all of their relevant national and international policymaking processes."⁸⁴

At the national level, the right to health can enhance health policies and also strengthen the position of health ministries. At the international level, the right to health can

contribute to the realization of the Millennium Declaration's vision of global equity and shared responsibility. Thus, the consistent and coherent application of the right to health across all national and international policy-making processes is one of the most important challenges confronting those committed to the promotion and protection of this fundamental human right.

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