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**The right of everyone to the enjoyment of the highest
attainable standard of physical and mental health**

**Report of the Special Rapporteur, Paul Hunt, submitted in
accordance with Commission resolution 2002/31* ****

* In accordance with General Assembly resolution 53/208 B, paragraph 8, this document is submitted late so as to include the most up-to-date information possible.

** The annexes to this document are circulated in the language of submission only.

Executive summary

In its resolution 2002/31, the Commission on Human Rights decided to appoint, for three years, a Special Rapporteur with a mandate to focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Paul Hunt (New Zealand) was appointed Special Rapporteur in August 2002. In this preliminary report, the Special Rapporteur outlines his general approach to the mandate.

After emphasizing the importance he attaches to developing a regular dialogue and discussing possible areas of cooperation with all relevant actors, the Special Rapporteur outlines the sources and scope of the right to health.

The report identifies three primary objectives for the mandate: 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 the operationalization of the right to health at the community, national and international levels.

The Special Rapporteur aims to explore these three objectives by way of two interrelated themes: the right to health and poverty (in this context the report briefly considers the health-related Millennium Declaration Goals); and the right to health, discrimination and stigma. Both themes permit the Special Rapporteur to examine a number of important issues arising from resolution 2002/31, such as gender, the needs of children, racial discrimination, and HIV/AIDS.

The report outlines six illustrative issues that, resources permitting, the Special Rapporteur would like to examine through the prism of the right to health: (a) poverty reduction strategies; (b) "neglected diseases"; (c) impact assessments; (d) relevant World Trade Organization Agreements; (e) mental health; (f) the role of health professionals.

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Introduction

1. In resolution 2002/31, the Commission on Human Rights decided to appoint, for a period of three years, a Special Rapporteur whose mandate will focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as reflected in article 25 (1) of the Universal Declaration of Human Rights (UDHR), article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), article 24 of the Convention on the Rights of the Child (CRC) and article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as well as on the right to non-discrimination as reflected in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).

2. The Special Rapporteur is requested to: (a) gather, request, receive and exchange right to health information from all relevant sources; (b) dialogue and discuss possible areas of cooperation with all relevant actors, including Governments, relevant United Nations bodies, specialized agencies and programmes, in particular the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS, as well as non-governmental organizations (NGOs) and international financial institutions; (c) report on the status, throughout the world, of the right to health, including laws, policies, good practices and obstacles; and (d) make recommendations on appropriate measures that promote and protect the right to health. The Special Rapporteur is further asked to apply a gender perspective and to pay special attention to the needs of children in the realization of the right to health, to take into account the relevant provisions, inter alia, of the Durban Declaration and Programme 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. The present preliminary report is submitted in accordance with resolution 2002/31.

Consultations and cooperation

3. Paul Hunt (New Zealand) was appointed Special Rapporteur in August 2002. Within the limited time available between his appointment and the deadline for submission of this preliminary report, the Special Rapporteur has consulted as widely as possible. On a preliminary and informal basis, the Special Rapporteur has consulted with some States and a wide range of WHO officials. Also, he has had preliminary, informal discussions with UNAIDS, UNICEF and the United Nations Population Fund and, in Washington DC, with officials of the World Bank and the International Monetary Fund (IMF). The Special Rapporteur has also consulted with civil society organizations, including associations of health professionals, such as the World Medical Association.

4. The Special Rapporteur met with, and greatly appreciated the support and encouragement of, the United Nations High Commissioner and Deputy High Commissioner for Human Rights.

5. In November 2002, International Service for Human Rights - in cooperation with the Francois-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, the Office of the High Commissioner for Human Rights and WHO - organized a briefing

at United Nations Headquarters for the Special Rapporteur to discuss his mandate with diplomats, United Nations agencies and NGOs. The Special Rapporteur would like to thank all those responsible for organizing this event.

6. The Special Rapporteur is grateful to all those with whom he has consulted and looks forward to deepening these consultations in the coming year. He attaches considerable importance to paragraph 5 (b) of his mandate, which enjoins him to “develop a regular dialogue and discuss possible areas of cooperation with all relevant actors”, and looks forward to consulting with those he has not yet had an opportunity to meet. The Special Rapporteur will welcome comments on the objectives (Part II), themes (Part III) and illustrative projects and issues (Part IV) that are outlined in this preliminary report.

7. In accordance with his mandate, the Special Rapporteur is keen, as opportunities arise and resources permit, to move from consultations to cooperation with the relevant national and international actors: Governments, national human rights institutions, United Nations human rights treaty bodies, thematic and country special rapporteurs and other independent experts, United Nations agencies and programmes, international financial institutions, health professionals, civil society organizations and others. For example, the Special Rapporteur would like to work with Ministries of Health, and other relevant ministries, helping them to identify laws, policies and programmes that promote and protect the right to health. As the Special Rapporteur will endeavour to show in the course of his mandate, the right to health can enhance health policies and also strengthen the position of health ministries at the national level. Further, 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.

A fundamental principle

8. In the course of his work, the Special Rapporteur will be guided by the fundamental principle that international human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policy-making processes. In the context of international policy-making, this principle is reflected in the Vienna Declaration and Programme of Action, as well as the Secretary-General’s reports *Renewing the United Nations: a programme for reform* (1997),¹ *Strengthening of the United Nations: an agenda for further change* (2002)² and *Road map towards implementation of the United Nations Millennium Declaration* (2001).³ Moreover, the principle is also reflected in the position taken by the Commission on Human Rights, such as its resolution calling upon States parties to ICESCR to “ensure that the Covenant is taken into account in all of their relevant national and international policy-making processes”.⁴

9. However, if this principle is to be more than a slogan, two questions have to be answered. First, what do human rights *in general* bring to the policy-making process? Second, what do *specific* human rights, such as the right to health, bring to the policy-making process? In the course of his work, the Special Rapporteur will endeavour to answer these two crucial questions - especially the second, focusing on the right to health.

I. THE HUMAN RIGHT TO HEALTH

A. Sources of the right to health

1. International

10. Adopted in 1946, the Constitution of WHO states: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Two years later, article 25 (1) UDHR laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. The following paragraphs provide a brief overview of selected legal sources of the right to health.

11. Article 12 of ICESCR provides the cornerstone protection of the right to health in international law: the Covenant introduces legally binding provisions that apply to all individuals in the 146 ratifying States. Additional right-to-health protections for marginalized groups are contained in group-specific international treaties. Article 5 (e) (iv) of ICERD provides protections for racial and ethnic groups in relation to “the right to public health (and) medical care”. CEDAW provides several provisions for the protection of women’s right to health, in particular articles 11 (1) f, 12 and 14 (2) b. CRC contains extensive and elaborate provisions on the child’s right to health, including article 24, which is fully dedicated to the right to the health of the child, and articles 3 (3), 17, 23, 25, 32 and 28, which contain protections for especially vulnerable groups of children. The Special Rapporteur also notes the “guiding principles” of CRC, contained in articles 2, 3, 6 and 12, which guide implementation of all Convention rights.

12. Further standards relating to specific groups are set out in other instruments, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare and the Declaration on the Elimination of Violence against Women. A list of group-specific international standards on the right to health is provided in annex I, section B. Additional international human rights instruments contain protections relevant to the right to health in various situations, environments and processes, including armed conflict, development, the workplace and detention. A list of these key context-specific international standards for the right to health is provided in annex I, section C.

13. Significantly, recent resolutions of the Commission, including on access to medication (2002/32) and disabilities (2002/61), have articulated the right to health, reaffirming its status as a human right. In addition, the Commission has adopted important resolutions containing provisions that bear closely upon the right to health (see annex II).

14. Far-reaching commitments relating to the right to health have been made in the outcome documents of numerous United Nations world conferences. These conferences help to place international problems, including health issues such as HIV/AIDS, at the top of the global agenda. Their outcome documents influence international and national policy-making. Many refer to the right to health and health-related rights, as well as health issues. A list of key outcome documents is provided in annex I, section D.

2. Regional

15. In addition to international standards, the right to health is recognized in regional human rights treaties, including the African Charter on Human and Peoples' Rights (art. 16); the African Charter on the Rights and Welfare of the Child (art. 14); the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the "Protocol of San Salvador" (art. 10); and the European Social Charter (art. 11).

16. Other regional instruments, which do not explicitly recognize the right to health but which offer indirect protections through other health-related rights, include the American Declaration on the Rights and Duties of Man, the American Convention on Human Rights, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, and the European Convention for the Protection of Human Rights and Fundamental Freedoms and its protocols.

17. Regional human rights mechanisms adjudicate cases involving the right to health. A notable case in 2002 was the finding by the African Commission on Human and Peoples' Rights of a violation of the right to enjoy the best attainable standard of physical and mental health by the Federal Republic of Nigeria, on account of violations against the Ogoni people in relation to the activities of oil companies in the Niger Delta.⁵

18. In other cases, regional mechanisms have found breaches of other health-related rights. For example, in *López Ostra v. Spain*, the European Court of Human Rights found that environmental harm to human health may amount to a violation of the right to a home and family and private life.⁶ In *ICJ v. Portugal*, the European Committee of Social Rights considered allegations relating to the occurrence of child labour in Portugal. In finding a breach of the European Social Charter, the Committee expressed concern that a significant number of children worked in sectors which "may have negative consequences on the children's health as well as on their development".⁷

19. In its admissibility decision in *Jorge Odir Miranda Cortez et al. v. El Salvador*, the Inter-American Commission on Human Rights held that while it was not competent to determine violations of article 10 (the right to health) of the Protocol of San Salvador, it would "take into account the provisions related to the right to health in its analysis of the merits of the case, pursuant to the provisions of articles 26 and 29 of the American Convention".⁸

3. Domestic

20. WHO has commissioned the International Commission of Jurists to embark upon a survey of national constitutions that enshrine the right to health and health-related rights.⁹ According to the preliminary findings of this study, which remains in its early stages, over 60 constitutional provisions include the right to health or the right to health care, while over 40 constitutional provisions include health-related rights, such as the right to reproductive health care, the right of the disabled to material assistance, and the right to a healthy environment. Further, a large number of constitutions set out State duties in relation to health, such as the State duty to develop health services, from which it may be possible to infer health entitlements. Moreover, in some jurisdictions constitutional provisions on the right to health

have generated significant jurisprudence, such as the recent decision of the Constitutional Court of South Africa in *Minister for Health v. Treatment Action Campaign*. In this case, the Court held that the Constitution required the Government “to devise and implement a comprehensive and coordinated programme to progressively realize the right of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV”.¹⁰ This case - and numerous other laws and decisions at the international, regional and national levels - confirms the justiciability of the right to health.

21. Over the course of his mandate, the Special Rapporteur proposes to examine constitutional (and other) law and practice concerning the right to health, with a view to clarifying the contours and content of the right to health and identifying good practice in relation to its implementation.

B. Contours and content of the right to health

22. Here the Special Rapporteur confines himself to some initial remarks about the jurisprudential content of the right to health.

23. *Health care and the underlying determinants of health.* 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 on sexual and reproductive health.¹¹

24. *Freedoms and entitlements.* The right to health contains both freedoms and entitlements. Freedoms include the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements 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.¹²

25. *More specific entitlements.*¹³ The right to health is a broad concept that can be broken down into more specific entitlements such as the rights to:

- Maternal, child and reproductive health;
- Healthy workplace and natural environments;
- The prevention, treatment and control of diseases, including access to essential medicines;
- Access to safe and potable water.

26. *Non-discrimination and equal treatment.* Non-discrimination and equal treatment are among the most critical components of the right to health. Accordingly, international human rights law proscribes any discrimination in access to health care, and the underlying determinants of health, on the internationally prohibited grounds, including health status, which has the intention or effect of impairing the equal enjoyment of the right to health.¹⁴

27. *Immediate obligations.* Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards 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 towards the full realization of the right to health.¹⁵

28. *International assistance and cooperation.* States have an obligation to take steps, individually and through international assistance and cooperation, towards 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 adversely impacts upon the right to health, and 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 policy-making matters.¹⁶

29. *Humanitarian assistance.* States have a joint and individual responsibility to cooperate in providing disaster relief and humanitarian assistance, including medical aid and potable water, in times of emergency, including assistance to refugees and internally displaced persons.¹⁷

30. *Responsibilities of all actors.* While States have primary responsibility for the realization of international human rights, all actors in society - individuals, local communities, intergovernmental and non-governmental organizations, health professionals, private businesses and so on - have responsibilities regarding the realization of the right to health.¹⁸

31. *Interdependence.* The right to health is closely related to the enjoyment of a number of other human rights and fundamental freedoms contained in the major international human rights treaties, including the rights to food, housing, work, education, life, non-discrimination, equality, the prohibition against torture, privacy, participation, access to information, and the freedoms of association, assembly and movement.¹⁹

32. *Limitations.* Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. Such limitations must be in accordance with the law, including international human rights standards, strictly necessary for the promotion of the general welfare in a democratic society, proportional, subject to review and of limited duration.²⁰

33. *Analytical frameworks.* In recent years, several human rights actors have developed analytical frameworks or tools that are designed to deepen our understanding of economic, social and cultural rights. In his forthcoming reports, the Special Rapporteur hopes to explore some or all of these developments.

34. First, CESCR observes that health facilities, goods and services, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality.²¹ The Committee explains each term - for example, "accessible" has four dimensions: accessible without discrimination, physically accessible, economically accessible (i.e. affordable), and accessible health-related information.

35. Second, CESCR, CEDAW and the Sub-Commission on the Promotion and Protection of Human Rights observe that human rights impose three types of obligations on States: the obligations to respect, protect and fulfil.²² A variation on this analysis is enshrined in the Constitution of South Africa.

36. Third, CESCR signals the importance of indicators and benchmarks.²³ The international right to health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a State needs a device to measure this variable dimension of the right to health. CESCR suggests that the most appropriate device is the combined application of national right to health indicators and benchmarks. Thus, a State selects appropriate right to health indicators that will help it monitor different dimensions of the right to health. Each indicator will require disaggregation on the prohibited grounds of discrimination. Then the State sets appropriate national targets - or benchmarks - in relation to each disaggregated indicator. It may use these national indicators and benchmarks to monitor its progress over time, enabling it to recognize when policy adjustments are required. Of course, no matter how sophisticated they might be, right to health indicators and benchmarks will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction. At best, they provide useful background indications regarding the right to health in a particular national context.

II. BROAD OBJECTIVES

37. The Special Rapporteur proposes to focus on three broad, interrelated objectives.

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**

38. Although a fundamental human right, with the same international legal status as freedom of religion or the right to a fair trial, the right to health is not as widely recognized as these and other civil and political rights. Many different actors, such as States, 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, one of the Special Rapporteur's objectives is to contribute to the more widespread recognition of the right to health 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?**

39. Although there is a growing national and international jurisprudence on the right to health, the legal content of the right is not yet well established. This is unsurprising given the historic neglect of the right to health, as well as other economic, social and cultural rights. Thus,

the Special Rapporteur aims to clarify and explore the contours and content of the right to health by drawing on (i) the evolving national and international jurisprudence, and (ii) the basic principles that animate international human rights law, such as equality, non-discrimination and the dignity of the individual.

3. To identify good practices for the operationalization of the right to health at the community, national and international levels

40. While it is of the first importance that human rights are recognized and their legal content understood, these legal provisions then have to be operationalized. In other words, the transition has to be made from national and international norms to effective policies, programmes and projects. However, it is not immediately obvious how to operationalize the right to health, any more than it is self-evident how to implement effectively a number of other human rights. Fortunately, in different jurisdictions there are examples of good laws, policies, programmes and projects that are reflective of the right to health. While what works in one context might not necessarily work in another, lessons can be learnt. Thus, the Special Rapporteur aims to collect, analyse and promote good practices on the right to health. These good practices will be taken from the community, national and international levels and they will relate to various actors including Governments, the courts, national human rights institutions, health professionals, civil society organizations and international organizations.

III. MAIN THEMES

41. The right to health extends across a wide and diverse range of issues, some of which are highly complex. With a view to making the mandate more manageable, the Special Rapporteur proposes to focus on two interrelated themes. He will not confine himself exclusively to them, but he proposes, broadly speaking, to organize his work around the twin themes of:

- (a) The right to health and poverty;
- (b) The right to health, discrimination and stigma.

42. As affirmed in the Millennium Declaration, poverty eradication has become one of the key overarching policy objectives of the United Nations, as well as other international organizations and many States. As for discrimination and stigma, both continue to seriously constrain and undermine progress in the field of health.

43. Under his mandate, the Special Rapporteur is enjoined “to apply a gender perspective” and “to pay special attention to the needs of children”, as well as the Durban Declaration and Programme of Action. The twin themes of poverty and discrimination/stigma especially lend themselves to these issues of gender, children and racial discrimination. The twin themes also lend themselves to an examination of other issues to which the Special Rapporteur attaches particular importance, such as mental health and HIV/AIDS.

A. Poverty and the right to health

44. The right to health - and other human rights - have a significant and constructive role to play in poverty reduction and similar strategies. Policies that are based on national and international human rights are more likely to be effective, sustainable, inclusive, equitable and meaningful to those living in poverty.²⁴

1. Health and poverty

45. Ill health causes poverty by destroying livelihoods, reducing worker productivity, lowering educational achievement and limiting opportunities. Because poverty may lead to diminished access to medical care, increased exposure to environmental risks, the worst forms of child labour and malnutrition, ill health is also often a consequence of poverty. 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.

46. Good health is central to creating and sustaining the capabilities that poor people need to escape from poverty. A key asset of the poor, good health contributes to their greater 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 United Nations Millennium Declaration and the Millennium Development Goals.²⁵

2. Millennium Development Goals (MDGs): the prominence of health

47. Of the eight MDGs, four are health-related:

(a) By the year 2015, to have reduced maternal mortality by three quarters of its current rate;

(b) By the year 2015, to have reduced under-5 child mortality by two thirds of its current rate;

(c) By 2015, to have halted and begun to reverse the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity;

(d) To ensure environmental sustainability.

Elements of a fifth MDG - developing a global partnership for development - also bear closely upon the right to health. Further, 8 of the 16 MDG "targets" and 17 of the MDG 48 "indicators" are health related.

48. Given that health is so prominent in the MDGs and their "targets" and "indicators", the Special Rapporteur proposes to consider, in the course of his work, the health-related MDGs through the prism of the right to health, with a view to contributing to their realization.

3. MDGs and the right to health

49. It has been correctly observed that the MDGs are not framed in terms of human rights. The Special Rapporteur notes three particular objections that may be made about the MDGs from the human rights perspective.

50. 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, the MDGs do not refer to reproductive health. This omission is especially striking because the Cairo and Beijing conference outcomes, as well as the International Development Targets (the forerunner of the MDGs), include reproductive health. The Special Rapporteur's response to this criticism is to emphasize that the MDGs are not intended to be comprehensive. There are crucial health-related goals and targets that fall outside the MDGs. It follows that the MDGs should be complemented and supplemented. Certainly, reproductive health is an integral element of the right to health and will have to be incorporated in any strategy reflective of the right to health.

51. Second, human rights have a particular preoccupation with vulnerable individuals and groups. From the human rights perspective, the average condition of the whole population is unhelpful and can even be misleading: improvements in average health indicators may actually mask a decline for some marginal groups. Thus, human rights require that all relevant data be disaggregated so the conditions of specifically disadvantaged groups - poor women, minorities, indigenous peoples, and so on - are captured. The health-related MDGs are sometimes criticized because they are not framed in this way: they are not disaggregated. The Special Rapporteur's response to this criticism is to suggest that this is precisely one contribution that the right to health can make to the health-related MDGs. By insisting on appropriate disaggregation, the right to health can help to identify policies that will deliver the promise of the Millennium Declaration to all individuals and groups.

52. Third, it might be argued that, from the human rights perspective, the goal of reducing maternal mortality by three quarters by 2015 is unacceptable: the human rights goal must be to eliminate all avoidable maternal mortality. The response to this objection is provided by the concept of progressive realization which is an integral feature of many human rights, including the right to health. The human rights approach does not make the unreasonable demand that all human rights must be realized overnight. In recognition of present realities, including resource constraints, it allows for the progressive realization of the right to health over a period of time.

53. Crucially, however, the human rights approach imposes conditions on the conduct of progressive realization - otherwise progressive realization can empty human rights of substance and turn them into mere rhetoric. To take one example of such a condition: the human rights approach demands that a State take all measures in its power to move as expeditiously and effectively as possible towards the full realization of the right to health. To take another example: the human rights approach demands that minimum essential levels - or core obligations - of the right to health should always be respected. Conditions such as these are designed to ensure that the concept of progressive realization is not abused. They also explain why effective, transparent and accessible monitoring and accountability arrangements are an essential feature of the human rights approach.

54. Thus, an MDG to reduce maternal mortality by three quarters by 2015 is certainly unacceptable from the human rights perspective - if it represents the final goal. But nobody suggests that such an MDG is a final goal: it is an intermediate goal. Given the concept of progressive realization, the Special Rapporteur does not see any 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 only be answered after a careful examination of the relevant human rights law and policy.

55. In conclusion, the Secretary-General's road map towards implementation of the United Nations Millennium Declaration also encourages the Special Rapporteur to consider the health-related MDGs through the prism of the right to health. According to the road map: "Economic, social and cultural rights are at the heart of all the millennium development goals."²⁶ Thus, the Special Rapporteur hopes to examine 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.

4. Human rights, the right to health and poverty

56. There is a growing literature and practice on the contribution of human rights, in general, to poverty reduction.²⁷ In brief, human rights empower the poor; help to 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 which have a disproportionately harmful impact upon 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.

57. There is less literature and practice on the specific contribution of the right to health to poverty reduction - and it is to this issue that the Special Rapporteur wishes to devote particular attention. The Special Rapporteur suggests that a poverty reduction strategy based upon the right to health would, for example, focus on: improving the poor's access to health services, e.g. by identifying diseases that have a particular impact on the poor and introducing immunization and other programmes that are specifically designed to reach the poor; improving the effectiveness of public health interventions to the poor, e.g. by implementing basic environmental controls, especially regarding 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; 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.

58. In conclusion, the Special Rapporteur will explore the specific contribution of the right to health to reducing poverty. This specific contribution has to be understood in the context of the general contribution of human rights - e.g. non-discrimination, participation, international cooperation, accountability - to poverty reduction.

B. Discrimination and stigma and the right to health

59. The Special Rapporteur proposes to focus on issues related to discrimination and stigma in the context of the right to health as a second key theme. Discrimination on 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 amongst 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 disabilities and diseases, like HIV/AIDS, tend to reinforce existing social divisions and inequalities.

60. Non-discrimination is among the most fundamental principles of international human rights law. According to CESCR, 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”.²⁸

61. As well as prohibiting discrimination on a range of specified grounds, such as race, colour, sex and religion, international human rights instruments also prohibit discrimination on the grounds of “or other status”. The Commission on Human Rights has interpreted this term to include health status.²⁹ Thus, the Commission and CESCR agree that States have an obligation to take measures against discrimination on the basis of health status, as well as the 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 sections of the population, without discrimination.³⁰

62. 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 vulnerability to ill health and hampers effective health interventions. The impact is compounded when an individual suffers double or multiple discrimination on the basis of, for example, gender, race, poverty and health status.

63. Effectively promoting the right to health will require identifying and analysing the complex ways in which discrimination and stigma impact on the enjoyment of the right to health of those affected, with particular attention to women, children and marginalized groups such as racial and ethnic minorities, indigenous peoples, persons with disabilities, people living with HIV/AIDS, refugees and the internally displaced and migrants. This will require gathering and analysing data with a view to better understanding the relationship between various forms of discrimination as determinants of health, recognizing the compounding effects of multiple forms

of discrimination, and documenting how discrimination and intolerance affect access to health and health care services. It will also require a careful balancing of the need to address discrimination and stigma in relation to health by encouraging the publication of disaggregated data and the development of policies and strategies to combat discrimination, while ensuring that publication of such data does not serve to perpetuate stigma.

64. The Special Rapporteur proposes, in the course of his mandate, to address the impact of stigma and discrimination in relation to particular populations.

1. Women

65. 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 family. Factors that compound the vulnerability of women to ill health include a lack of access to information, education and services necessary to ensure sexual and reproductive health; violence, including sexual violence; harmful traditional practices; and lack of legal capacity and equality in family matters.³¹ States have an obligation to ensure equal access of men and women to the enjoyment of all rights, including by ensuring equality and non-discrimination in areas such as political rights, marriage and family, employment and health.

2. Racial and ethnic minorities

66. Racism, racial discrimination and related intolerance contribute to inequalities in relation to the health and health care of ethnic and racial groups.³² ICERD requires States to prohibit and to eliminate racial discrimination, and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the right to health and medical care. At the World Conference against Racism, Governments identified the need to recognize racism as a significant social determinant of health and access to health care.³³ They committed to enhancing measures to fulfil the right of everyone to the highest attainable standard of health, with a view to eliminating disparities in health status which might result from racial discrimination. They also agreed to a series of measures, from preventing genetic research to be used for discriminatory purposes to tackling discrimination in health systems.³⁴

3. People with disabilities

67. People living with disabilities are exposed to various forms of discrimination and social exclusion which prevent them from exercising their rights and freedoms and from participating fully in their societies.³⁵ The discrimination they experience may range from the denial of health services, employment and educational opportunities, to exclusion and isolation deriving from physical and social barriers. Women with disabilities may be particularly at risk due to stigmas associated with both disability and gender, and are more likely to suffer from discrimination than able-bodied women or men with disabilities.

4. People living with HIV/AIDS

68. Stigma associated with HIV/AIDS builds upon and reinforces prejudices related to gender, poverty, sexuality, race and other factors. Fears related to illness and death; the association of HIV with sex workers, men having sex with men and injecting drug use; and beliefs that attribute moral fault to people living with HIV/AIDS all contribute to the impact of stigma and often give rise to intolerance and discrimination.³⁶ 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 identified with HIV/AIDS stops people from seeking voluntary counselling and testing, which are vital to prevention, care and treatment efforts. 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 to combat stigma and social exclusion connected with the epidemic.³⁷

IV. SPECIFIC PROJECTS, ISSUES AND INTERVENTIONS

69. Given the Special Rapporteur's interpretation of the right to health (Part I), his objectives (Part II) and twin themes (Part III), what are examples of the specific projects, issues and interventions that he proposes to pursue? The Special Rapporteur will welcome comments on the following illustrative projects and issues. He is not suggesting that he will have the capacity to take up all of the projects and issues sketched out below: that will depend upon his resources and opportunities. Nor is he saying that he will confine himself only to these projects and issues: other interventions may arise. Nonetheless, the following illustrations indicate the type of specific projects and issues that he proposes to undertake.

A. Poverty reduction strategies

70. Poverty is a global phenomenon experienced in varying degrees by all States. An increasing number of States - developed, developing and societies in transition - are formulating poverty reduction strategies. The Special Rapporteur proposes 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.

71. Poverty reduction strategy papers (PRSPs), deriving from the Heavily Indebted Poor Countries (HIPC) initiative, are one category of anti-poverty strategy. WHO recently carried out a desk review of 10 full PRSPs and 3 interim PRSPs. This preliminary study found little evidence of attempts to adapt national health strategies to meet the needs of the poorest.³⁸ Very few PRSPs built in any health indicators that would monitor the impact on poor people or regions.³⁹ No PRSPs contained plans to include poor people in a participatory monitoring process.⁴⁰ All of these shortcomings would have been, at least, attenuated if the right to health had been taken fully into account during the formulation of the relevant PRSP. It is no surprise that the study also found that no PRSP mentioned health as a human right.⁴¹

72. The Special Rapporteur will not confine his examination to the anti-poverty strategies of HIPC and developing States. He proposes to examine, through the prism of the right to health, some developed States' anti-poverty strategies. Moreover, the poverty reduction strategy of a developed State should address two different constituencies. The strategy should address poverty in (i) the developed State's own jurisdiction and (ii) developing States. A developed State has to ask: given the obligation of international assistance, what contribution is it making to the reduction of poverty in the South? Norway, for example, has recently published *Fighting Poverty: The Norwegian Government's Action Plan for Combating Poverty in the South towards 2015*.⁴² Accordingly, the Special Rapporteur would like to examine, through the prism of the right to health, developed States' strategies for the reduction of poverty in both their jurisdictions and in the South.

B. Neglected diseases

73. Broadly speaking, there are three types of disease. Type I diseases occur in both rich and poor countries, with large numbers of vulnerable populations in each, e.g. hepatitis B. Type II diseases - often termed neglected diseases - occur in both rich and poor countries, but with a substantial proportion of the cases in the poor countries, e.g. HIV/AIDS and tuberculosis.

74. Type III diseases - often termed very neglected diseases - are those that overwhelmingly or exclusively occur in developing countries, such as river blindness and sleeping sickness. According to a recent WHO report, *Global Defence against the Infectious Disease Threat*, the "health impact of these neglected 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".⁴³ The report continues:

"The so-called 'neglected' 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... Neglected diseases can help to guarantee that the next generation remains anchored in poverty... The disabilities caused by most of these diseases are associated with great stigma."⁴⁴

75. These three categories are not rigid: some diseases straddle two categories, e.g. malaria falls between types II and III.

76. In the case of type I diseases, incentives for research and development exist in the 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, in relation to poor

countries, is access to those technologies, which tend to be high priced and under patent protection. Many vaccines for type I diseases have been developed in the past 20 years but have not been widely introduced into the poor countries because of cost.

77. In the case of type II diseases, research and development incentives exist in the rich country markets, but the level of research and development spending on a global basis is not commensurate with the disease burden. In the case of vaccines for HIV/AIDS, for example, substantial research and development is under way as a result of rich-country market demand, but not in proportion to global need or addressed to the specific disease conditions of the poor countries.

78. Type III diseases - the very neglected diseases - receive extremely little research and development, and essentially no commercially based research and development in the rich countries. Because of poverty, the market mechanism fails. Moreover, poor-country Governments lack the means to subsidize the needed research and development. Thus, research and development for diseases specific to poor countries tends to be grossly underfinanced. As the Report of the WHO Commission on Macroeconomics and Health puts it: "The poor countries benefit from R & D mainly when the rich also suffer from the same diseases."⁴⁵

79. The imbalance of research between diseases of the poor (type II and especially type III diseases) and of the rich has been documented for more than a decade. In 1990, the Commission on Health Research and Development noted what became known as the 10/90 disequilibrium: only 10 per cent of research and development spending is directed at the health problems of 90 per cent of the world's population. Initiatives have been launched to address this imbalance - and some progress has been made - but the initiatives remain profoundly underfunded.

80. Recently, the problem of neglected diseases - a neglect arising from market and public policy failures - has been given fresh impetus by a number of welcome developments, including the Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Special Rapporteur stresses the urgent need for the Global Fund to mobilize and disburse additional resources for fighting these three diseases.

81. In his work, the Special Rapporteur wishes to give particular attention to the numerous right-to-health implications of neglected (including very neglected) diseases and the 10/90 disequilibrium: non-discrimination, equality, the availability and accessibility of health facilities, goods and services (including drugs), international assistance and cooperation, and so on. The basic point is this: neglected diseases, very neglected diseases and the 10/90 disequilibrium are human rights issues.

C. Impact assessments

82. 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.⁴⁶ If a State has adopted poverty reduction as its major policy objective, it must

ensure that any new law or policy is consistent with that policy goal. Rigorous policy-making demands an analysis of the distributional impact of reforms on the well-being of different groups in society, especially the poor and vulnerable. Such an analysis has to consider - before, during and after implementation of any relevant policy intervention - the intended and unintended consequences of the initiative, with a view to identifying appropriate mitigating or other measures. This requirement of socially responsible impact analysis applies to States and other actors in the context of national and international policies.

83. Of course, there are obstacles to the preparation of rigorous impact analyses. The authors of a recent IMF publication remark that these obstacles include “[d]ata limitations, weak national capacity, and a lack of donor coordination”.⁴⁷ They recommend that poverty and social impact analyses should be strengthened,⁴⁸ 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”.⁴⁹

84. 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.⁵⁰ 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.⁵¹ The World Bank has recently prepared a lengthy draft *User’s Guide to Poverty and Social Impact Analysis*. Some civil society organizations have advocated the introduction of “poverty impact assessments” within the framework of the PRSP process.⁵² Human rights impact assessments have been suggested for many years, most prominently in the Vienna Declaration and Programme of Action,⁵³ and a few actors have sought to put them into practice.⁵⁴

85. 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 policy-making processes. Accordingly, the Special Rapporteur wishes to examine, in the context of the right to health, the different types of impact analyses with a view to identifying good practice for States and other actors.

D. World Trade Organization and the right to health

86. It is not possible in a preliminary report of this nature to 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 2002.⁵⁵ What is clear, however, is that both Agreements bear upon crucial elements of the right to health. TRIPS, for example, impacts upon the 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”.⁵⁶

87. The Special Rapporteur notes the significance of the Declaration on the TRIPS Agreement and Public Health that was adopted at the WTO Fourth Ministerial Conference in Doha during November 2001.⁵⁷ 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”.⁵⁸ 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”.⁵⁹ In this way, the Declaration reflects human rights perspectives, especially the right to health and the right to enjoy the benefits of scientific progress, which is enshrined in article 27 of the Universal Declaration of Human Rights.

88. GATS is the first multilateral agreement governing all forms of international trade in services, including health services. Negotiations on further liberalization of trade in services are currently under way, scheduled to be completed by January 2005. The liberalization of trade in health services can impact on the right to health in various ways, depending on a range of issues, not least the regulatory environment. One issue of particular relevance is the effect of increased foreign direct investment (FDI) 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 them at 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.”⁶⁰

89. The Special Rapporteur notes that the Commission on Human Rights in its resolution 2002/32 called upon 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” (para. 6 (b)). In these circumstances, so far as his resources permit, the Special Rapporteur wishes to monitor and examine trade rules and policies in the context of the right to health, including implementation of the Doha Declaration, in the lead-up to the WTO Fifth Ministerial Conference to be held in September 2003.⁶¹

E. The right to mental health

90. In 2001, WHO estimated that 450 million people suffer from a mental or behavioural disorder and that these disorders account for 12 per cent of the global burden of disease.⁶² Mental disorders include schizophrenia, bipolar disorder, depression, mental retardation, Alzheimers and other dementias. They are common in all countries. The poor and other marginalized groups tend to be disproportionately affected, in both developed and developing countries.

91. 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 over 40 per cent of countries do not have a mental health policy; mental health budgets of most countries account for less than 1 per cent of their health budgets.⁶³

92. For the 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 countries and within countries. The Special Rapporteur is concerned that in many States mental health care often consists primarily of large psychiatric institutions, with limited provision of community-based treatment and care.⁶⁴

93. The Special Rapporteur is alarmed by the wide range of human rights violations that 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.⁶⁵ The Special Rapporteur also notes the stigma and discrimination surrounding mental disorders, as well as the real or deemed incapacity of persons with mental disorders to take decisions on account 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.

94. The Special Rapporteur proposes to give particular attention to the right to mental health, without duplicating or overlapping with the work of other relevant international bodies.

F. Health professionals

95. As providers of health services, health professionals play an indispensable role in the promotion and protection of the right to health. The Special Rapporteur proposes to explore the important role played by health professionals in relation to the right to health, as well as the difficulties impeding their practice.

96. In many countries, health professionals are poorly paid and work long hours with shortages of equipment in obsolete facilities. Poor terms and conditions of employment are a major cause of the "brain drain": the migration of medical practitioners mainly from the South to the North, but also rural-to-urban migration within individual countries.⁶⁶ While some benefits may accrue to the exporting countries (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 these.⁶⁷ Poor terms and conditions also contribute to several other problems, including the phenomenon of better trained medical practitioners going to work in the private sector for more favourable terms and conditions, thereby depleting public health systems.

97. In some countries, on account of their professional activities, health workers have been victims of discrimination, arbitrary detention, arbitrary killings and torture, and have had their freedoms of opinion, speech and movement curtailed. Those who are at particular risk include

health professionals working with patients who are victims 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.⁶⁸

98. The Special Rapporteur notes the problem of corruption in the provision of health services. While, in some cases, this problem derives from the unsatisfactory terms and conditions of health professionals, corruption in health services is not confined to health workers. Nor is it confined to one region of the world. What is clear is that corruption disadvantages 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."⁶⁹ Interestingly, a recent IMF study of corruption in health-care services concludes: "participation of the poor in the decisions that influence the allocation of public resources would mitigate corruption possibilities".⁷⁰ While allowing that there are no quick solutions, the Special Rapporteur takes the view that corruption is an issue of both the right to health and poverty.

V. CONCLUSION

99. **This preliminary report signals some of the large and complex issues encompassed by the right to health. For those committed to the right to health, perhaps the greatest challenge is to navigate the numerous, complex and vital issues and arrive at practical, achievable recommendations. For this reason, the Special Rapporteur attaches particular importance to his third objective: the identification of good practices for the operationalization of the right to health at the community, national and international levels. With the assistance of others, he hopes to set out some of these good practices in his subsequent reports.**

Notes

¹ A/51/950, paras. 78-79.

² A/57/387, para. 48.

³ A/56/326, paras. 202 and 204.

⁴ Resolution 2002/24, para. 7.

⁵ Communication 155/96, *SERAC and CESR v. Nigeria*, Fifteenth Annual Activity Report of ACHPR, 2001-2002, annex V.

⁶ *López Ostra v. Spain*, ECtHR, 1994.

⁷ Complaint 1/1998, *ICJ v. Portugal*, ECSR, 1999.

⁸ *Jorge Odir Miranda Cortez et al. v. El Salvador*, IACHR, 2001, para. 47.

⁹ ICJ, *Right to Health Database, Preliminary Proposal*, 2002.

- ¹⁰ Constitutional Court of South Africa, Case CCT 8/02, para. 135 (2) (a).
- ¹¹ See for example, CESCR General Comment No. 14, (E/C.12/2000/4), para. 8.
- ¹² Ibid., para. 11.
- ¹³ Ibid., paras. 14-17 and CESCR General Comment No. 15 (E/C.12/2002/11).
- ¹⁴ See for example CESCR General Comment No. 14, paras. 18-21 and A/54/38/Rev.1, CEDAW General Recommendation 24, 1999.
- ¹⁵ See for example CESCR General Comment No. 14, paras. 30-31. CESCR also uses the term “core obligations”; see General Comment No. 14, paras. 43-45. On core obligations, see Chapman and Russell (eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Intersentia, 2002.
- ¹⁶ Ibid., paras. 38-39. Note Judge Weeramantry’s dissenting opinion in the Advisory Opinion of the International Court of Justice on the *Legality of the Threat or Use of Nuclear Weapons*, in which he cited article 12 of ICESCR and then stated, in relation to this article, that “it will be noted here that the recognition by States of the right to health is in the general terms that they recognize the right of ‘everyone’ and not merely of their own subjects. Consequently, each State is under an obligation to respect the right to health of all members of the international community” (*ICJ Reports*, 1996, vol. I, p. 144).
- ¹⁷ Ibid., para. 40.
- ¹⁸ See for example UDHR, preamble, and CESCR General Comment No. 14, paragraph 42.
- ¹⁹ See for example Vienna Declaration and Programme of Action, 1993, Part 1, paragraph 5, and CESCR General Comment No. 14, paragraph 3.
- ²⁰ See for example CESCR General Comment No. 14, paragraphs 28-29; and the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights (E/CN.4/1985/4, annex).
- ²¹ CESCR General Comment No. 14, para. 12. This mode of analysis resonates with the work of the United Nations Special Rapporteur on the right to education.
- ²² CESCR General Comment No. 14, para. 33 and passim.
- ²³ Ibid., paras. 57-58.
- ²⁴ See CESCR Statement on poverty (E/C.12/2001/10).
- ²⁵ General Assembly resolution 55/2.

²⁶ A/56/326, para. 202.

²⁷ For example, following a request from CESCER, OHCHR prepared Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies, September 2002.

²⁸ General Comment No. 14, para 18.

²⁹ See for example Commission resolutions 1994/49, 1995/44, 1996/43, 1999/49, 2001/51.

³⁰ General Comment No. 14, para. 12 (b) (i).

³¹ CEDAW General Recommendation 24; CEDAW General Recommendation 15.

³² See *Health and Freedom from Discrimination: WHO's Contribution to the World Conference against Racism*, Health and Human Rights Publication Series, August 2001.

³³ Durban Declaration and Programme of Action (A/CONF.189/5).

³⁴ Ibid., see, for example, paragraphs 8 (c), 58, 73, 109, 110 (b).

³⁵ See, for example, Quinn and Degener, *Human Rights and Disability: The Current Use and Future Potential of the United Nations Human Rights Instruments in the Context of Disability*, OHCHR, 2002.

³⁶ Fighting HIV-related Intolerance: Exposing the Links Between Racism, Stigma and Discrimination, paper prepared by WHO and UNAIDS in consultation with OHCHR, August 2001.

³⁷ General Assembly resolution S-26/2 of 27 June 2001, annex.

³⁸ Dodd and Hinshelwood, *PRSPs: Their Significance for Health*, draft presented to the WHO Meeting of Interested Parties, October 2002, p. 4.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Ibid, p. 9.

⁴² Norwegian Ministry of Foreign Affairs, 2002.

⁴³ WHO, 2002, p. iv.

⁴⁴ Ibid, p. 96.

⁴⁵ *Macroeconomics and Health: Investing in Health for Economic Development*, WHO, 2001, p. 77.

⁴⁶ As the Vienna Declaration and Programme of Action puts it: “protection and promotion [of human rights and fundamental freedoms] is the first responsibility of Governments” (Part I, para. 1).

⁴⁷ Gupta et al, *Is the PRGF Living Up to Expectations? An Assessment of Program Design*, IMF Occasional Paper 216, 2002, p. 32.

⁴⁸ Ibid, p. 35.

⁴⁹ Ibid, p. 36.

⁵⁰ See Equality Commission for Northern Ireland, *Section 75 of the Northern Ireland Act 1998: Practical Guidance on Equality Impact Assessment*.

⁵¹ For example the Institute for Public Health in Ireland, *Health Impact Assessment: An Introductory Paper*, September 2001. Also see Part II of Mann, Gruskin, Grodin and Annas (eds.), *Health and Human Rights: A Reader*, Routledge, 1999.

⁵² *Making PRSPs Work: The Role of Poverty Assessments*, Oxfam, 2001.

⁵³ Part II, para. 2.

⁵⁴ For example Norwegian Agency for Development Cooperation, *Handbook in Human Rights Assessment: State Obligations, Awareness and Empowerment*, 2001.

⁵⁵ E/CN.4/Sub.2/2001/13 and E/CN.4/Sub.2/2002/9. Also see CESCR statement on human rights and intellectual property (E/C.12/2001/15).

⁵⁶ Commission resolution 2002/32, para. 1.

⁵⁷ WT/MIN(01)/DEC/2, 2001.

⁵⁸ Ibid. para. 1.

⁵⁹ Ibid. para. 4.

⁶⁰ *WTO Agreements and Public Health: A Joint Study by the WHO and WTO Secretariat*, 2002, p. 18.

⁶¹ See Dommen, “Raising Human Rights Concerns in the WTO”, *Human Rights Quarterly*, vol. 24, No. 1, 2002, p. 1.

⁶² WHO. *The World Health Report 2001: Mental Health: New Understanding, New Hope*, p. 3.

⁶³ Ibid, p. 3.

⁶⁴ Ibid, p. 87.

⁶⁵ See for example *Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo*, Mental Disability Rights International, 2002.

⁶⁶ See for example see Pang, Lansang and Haines, "Brain Drain and Health Professionals", *British Medical Journal*, vol. 324, Issue 7336, p. 499.

⁶⁷ See for example UNCTAD/WHO, *International Trade in Health Services: A Development Perspective*, 1998.

⁶⁸ See for example Somerville, *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, BMA/Zed Books, 2001; *Directory of Persecuted Scientists, Health Professionals, and Engineers*, American Association for the Advancement of Science, 1999.

⁶⁹ Narayan, *Voices of the Poor: Can Anyone Hear Us?*, World Bank, 2000, p. 111.

⁷⁰ Gupta, Davoodi and Tiongson, "Corruption and the Provision of Health Care and Education Services", in *Governance, Corruption, and Economic Performance*, Abed and Gupta (eds.), IMF, 2002, p. 272.

Annex I

SOME INTERNATIONAL INSTRUMENTS RELEVANT TO THE RIGHT TO HEALTH

This annex lists some of the international instruments that are relevant to the right to health. Section A contains general international human rights instruments. Section B contains international instruments that relate to specific groups. Section C contains context-specific instruments. Inevitably, there is some overlap between sections B and C. To avoid repetition, instruments applying to both groups and contexts are categorized according to the group (sect. B). Section D contains international conference outcomes and their follow-ups.

This annex is not comprehensive: there are other instruments that are relevant to the right to health. Further standards are referenced in WHO, *25 Questions and Answers on Health and Human Rights*, Health and Human Rights Publications Series Issue 1, 2002; and G. Alfredsson and K. Tomaševski (eds.), *A Thematic Guide to Documents on Health and Human Rights: Global and Regional Standards Adopted by Intergovernmental Organizations, International Non-governmental Organizations, and Professional Associations* (Nijhoff, 1998).

A. General international instruments

1. Universal Declaration of Human Rights (1948); International Covenant on Economic, Social and Cultural Rights (1966); Constitution of the World Health Organization (1946); General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) on the right to health (2000).

B. International instruments relating to specific groups

2. *Racial and ethnic groups*: International Covenant on the Elimination of All Forms of Racial Discrimination (1965); ILO Convention No. 169 (concerning Indigenous and Tribal Peoples in Independent Countries, 1989); Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992).

3. *Women*: Convention on the Elimination of All Forms of Discrimination against Women (1979); Declaration on the Elimination of Violence against Women (1993); General Recommendation No. 14 of the Committee on the Elimination of Discrimination against Women (CEDAW) on female circumcision (1990); General Recommendation No. 19 of CEDAW on violence against women (1992); General Recommendation No. 24 of CEDAW on women and health (1999).

4. *Children*: Convention on the Rights of the Child (1989); ILO Convention No. 138 (concerning Minimum Age for Admission to Employment, 1973); ILO Convention No. 182 (the Worst Forms of Child Labour Convention, 1999); United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985); United Nations Rules for the Protection of Juveniles Deprived of Their Liberty (1990); Declaration on the Rights of the Child (1959).

5. *Migrant workers*: International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).
6. *People with disabilities including mental disabilities*: Declaration on the Rights of Disabled Persons (1975); Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993); Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare (1991); CESCR General Comment 5 on persons with disabilities (1994); Human Rights Committee General Comment 21 (1992).
7. *Older people*: United Nations Principles for Older Persons (1991); CESCR General Comment No. 6 on the economic, social and cultural rights of older persons (1995).
8. *Refugees*: Convention relating to the Status of Refugees (1951).

C. International instruments relating to specific contexts

9. *Armed conflict*: The Geneva Convention for the Amelioration of the Condition of Wounded and Sick in Armed Forces in the Field (1949); the Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (1949); the Geneva Convention relative to the Treatment of Prisoners of War (1949); the Geneva Convention relative to the Protection of Civilian Persons in Times of War (1949); Additional Protocol 1 to the Geneva Conventions relating to the Protection of Victims in International Armed Conflict (1977); Additional Protocol II to the Geneva Conventions relating to the Protection of Victims of Non-International Armed Conflicts (1977); Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974); Protocol on Prohibitions or Restrictions on the Use of Mines (1980).
10. *Occupational health and safety*: ILO Convention No. 155 (Occupational Health and Safety Convention, 1981); ILO Convention No. 148 (Working Environment Convention, 1977); and several other ILO Conventions (e.g. Conventions Nos. 130, 152, 161, 164, 167, 170, 171, 176, 177 and 184).
11. *Environmental health*: Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal (1989); Code of Practice on the International Transboundary Movement of Radioactive Waste (1990); Convention on Nuclear Safety (1994).
12. *Administration of Justice*: International Covenant on Civil and Political Rights (ICCPR, 1966); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT, 1984); Standard Minimum Rules for the Treatment of Prisoners (1955); Body of Principles for the Protection of All Persons under any Form of Detention or Imprisonment (1988); Code of Conduct for Law Enforcement Officials (1979); Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982).
13. *Development*: Declaration on the Right to Development (1986).

14. *Research, experimentation and genetics*: Nürnberg Code (1947); ICCPR; Universal Declaration on the Human Genome and Human Rights (1997); Declaration on the Use of Scientific and Technical Progress in the Interests of Peace and for the Benefits of Mankind (1975); General Comment No. 20 of the Human Rights Committee (1992).

15. *Data Protection*: Guidelines for the Regulation of Computerized Personal Data Files (1990); General Comment 16 of the Human Rights Committee (1988).

16. *Nutritional Health*: Universal Declaration on the Eradication of Hunger and Malnutrition (1974).

**D. Some international conference outcomes, and their follow-ups,
that relate to the right to health**

17. Johannesburg Declaration and Plan of Implementation of the World Summit for Sustainable Development (2002).

18. Monterrey Consensus of the International Conference on Financing for Development (2002).

19. Political Declaration and Madrid International Plan of Action on Ageing of the Second World Assembly on Ageing (2002).

20. “A World Fit for Children” adopted by the United Nations General Assembly Special Session on Children (2002); Declaration and Plan of Action of the World Summit for Children (1990).

21. Declaration of Commitment on HIV/AIDS, “Global Crisis-Global Action”, adopted by the United Nations General Assembly Special Session on HIV/AIDS (2001).

22. Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001).

23. United Nations Millennium Declaration, adopted by the United Nations General Assembly “Millennium Assembly of the United Nations” (2000).

24. Beijing Declaration and Platform for Action of the Fourth World Conference on Women (1995) and its follow-up, Beijing Plus 5 (2000).

25. Rome Declaration on World Food Security and World Food Summit Plan of Action of the World Food Summit (1996) and its follow-up, Declaration of the World Food Summit: Five Years Later, International Alliance Against Hunger (2002).

26. Istanbul Declaration and the Habitat Agenda of the Second United Nations Conference on Human Settlements (Habitat II) (1996), and the Declaration on Cities and Other Human Settlements in the New Millennium of the Special Session of the General Assembly for an overall review and appraisal of the implementation of the Habitat Agenda (2001).

27. Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development (1995) and its follow-up, Copenhagen Plus 5 (2000).
28. Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993).
29. Rio Declaration on Environment and Development and Agenda 21 of the United Nations Conference on Environment and Development (1992).
30. Stockholm Declaration of the United Nations Conference on the Human Environment (1972).

Annex II

SOME RECENT COMMISSION ON HUMAN RIGHTS RESOLUTIONS RELATING TO THE RIGHT TO HEALTH

Some resolutions explicitly referring to the right to health or aspects of the right to health

1. Resolution 2002/61 on human rights of persons with disabilities.
2. Resolutions 2002/32 and 2001/33 on access to medication in the context of pandemics such as HIV/AIDS.
3. Resolution 2002/31 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
4. Resolution 2001/35 on adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights.
5. Resolutions 2001/27 and 2000/82 on effects of structural adjustment policies and foreign debt on the full enjoyment of all human rights, particularly economic, social and cultural rights.

Some resolutions with provisions bearing significantly on the right to health

6. Resolution 2002/92 on the rights of the child.
7. Resolution 2002/65 on human rights and indigenous issues.
8. Resolution 2002/52 on elimination of violence against women.
9. Resolution 2002/51 on traffic in women and girls.
10. Resolution 2002/39 on protection of migrants and their families.
11. Resolution 2002/23 on the right to education.
12. Resolution 2001/71 on human rights and bioethics.
13. Resolution 2001/51 on the protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS).

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