A

ADVANCE EDITED VERSION

Distr.
GENERAL

A/HRC/4/28
17 January 2007

Original: ENGLISH

HUMAN RIGHTS COUNCIL
Fourth session
Item 2 of the provisional agenda

IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 60/251 OF 15 MARCH 2006 ENTITLED "HUMAN RIGHTS COUNCIL"

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

* The notes to this report are contained in the annex, which is reproduced as received in the language of submission only.

Summary

This report, submitted in accordance with Human Rights Council decision 1/102, contains two substantive sections. The first signals some of the progress made by the health and human rights movement in the last decade and it also discusses two of the key obstacles that lie ahead.

As never before, civil society - especially in low- and middle-income countries - is engaging with health and human rights. Some States are taking health and human rights seriously. General comment No. 14 of the Committee on Economic, Social and Cultural Rights provides authoritative guidance on the scope of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("the right to the highest attainable standard of health" or "the right to health"). Since 2000, numerous reports have explored how the right to health can be operationalized. Law cases, literature and courses on health and human rights are increasingly common.

There is a new maturity about the health and human rights movement as it endeavours to integrate human rights into health policies at the national and international levels. In addition to the traditional human rights techniques, such as "naming and shaming", the health and human rights movement is also using approaches such as indicators, benchmarks and impact assessments.

However, the health and human rights movement is also confronted with a range of major obstacles. The present report focuses on two of them: the inadequate engagement within the health and human rights movement of (i) established human rights non-governmental organizations and (ii) health professionals.

The report urges established human rights non-governmental organizations to work on health and human rights issues, such as maternal mortality, just as vigorously as they already campaign on disappearances, torture and prisoners of conscience.

The report also emphasizes that health and human rights not only occupy much common ground, but also complement and reinforce each other. Nevertheless, many health professionals have never heard of the right to the highest attainable standard of health. The report argues that there is no chance of operationalizing the right to health without the active engagement of many more health professionals, and it makes some preliminary observations about steps that might be taken to deepen health professionals' engagement in the health and human rights movement.

In recent years, the right to the highest attainable standard of health, as well as other health-related rights, have generated an increasingly rich case law. The report's second substantive section explains that judicial accountability has enhanced protection for the right to health and other health-related rights, and also deepened understanding of what these human rights mean. The section includes a sample of cases that signal how various tribunals have interpreted and applied health-related human rights.

CONTENTS

		Paragraphs	*Page*
I.	INTRODUCTION	1 - 5	4
II.	THE HEALTH AND HUMAN RIGHTS MOVEMENT: PROGRESS AND OBSTACLES	6 - 54	5
	A. Recent progress	7 - 11	5
	B. Civil society, health and human rights	12 - 17	6
	C. Operationalizing the right to health: the Special Rapporteur's contribution	18 - 24	7
	D. New skills and techniques	25 - 30	9
	E. The pivotal role of established human rights civil society organizations	31 - 37	10
	F. The pivotal role of health professionals	38 - 47	11
	G. Conclusion	48 - 54	13
III.	CASES ON THE RIGHT TO HEALTH AND OTHER HEALTH-RELATED RIGHTS	55 - 89	15
	A. Introduction	55 - 58	15
	B. Progressive realization, resource availability and immediate obligations	59 - 67	15
	C. Available, accessible, acceptable and of good quality	68 - 76	19
	D. The duties to respect, protect and fulfil	77 - 86	
	E. Conclusion	87 - 89	21
IV.	CONCLUSIONS	90 - 93	22
Annex - Notes to the report			23

I. INTRODUCTION

1. By its resolution 60/251 of 15 March 2006, the General Assembly concluded the work of the Commission on Human Rights and created the Human Rights Council. The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health is set out in Commission resolutions 2002/31 and 2004/27. The Human Rights Council, by its decision 1/102, extended all the mandates of the former Commission on Human Rights, including that of the Special Rapporteur. The present report is submitted in accordance with that decision.

2. In October 2006, the Special Rapporteur presented a report to the General Assembly (see A/61/338). The report explored two main themes: maternal mortality and the right to medicines. It also included information on the Special Rapporteur's mandate activities during the period January-August 2006. While in New York to present his report, the Special Rapporteur participated in a briefing on his mandate, organized for non-governmental organizations (NGOs) by the New York Office of the Office of the High Commissioner for Human Rights. He also attended a meeting with staff of the United Nations Population Fund (UNFPA).

3. In September 2006, the Special Rapporteur, together with the Special Rapporteur on adequate housing, Mr. Miloon Kothari, the Representative of the Secretary-General on human rights of internally displaced persons, Mr. Walter Kälin, and the Special Rapporteur on extrajudicial, summary or arbitrary executions, Mr. Philip Alston, visited Lebanon and Israel at the invitation of their Governments. A report on the mission (A/HRC/2/7) was submitted and presented to the Human Rights Council the following month.

4. In October 2006, the Special Rapporteur visited Peru where he had meetings following up on his country mission of June 2004 (see E/CN.4/2005/51/Add.3). He met with the Vice-Minister of Health, the Minister for Women, and representatives of the Ministry of Justice and Foreign Affairs. He held a meeting with many congresswomen and congressmen, and also met with the Defensoria del Pueblo (Ombuds) and her colleagues. He also met with representatives of the Pan-American Health Organization (PAHO), UNFPA, UNAIDS and other international organizations, as well as with civil society, and visited Victor Larco Herrera psychiatric hospital in Lima. Following this visit, the Special Rapporteur is requesting further information about follow-up undertaken in response to recommendations included in the report on his 2004 mission.

5. In the same month, the Special Rapporteur travelled to Washington, DC, where he met with the Executive Directors of the Nordic-Baltic Departments in the World Bank and International Monetary Fund (IMF). This official visit was undertaken by way of follow-up to his mission to Sweden in January 2006. A report on this visit to the World Bank and IMF will be presented to the Human Rights Council in 2007.[1]

II. THE HEALTH AND HUMAN RIGHTS MOVEMENT: PROGRESS AND OBSTACLES

6. Thanks to the work of innumerable organizations and individuals, the health and human rights movement has made striking progress in the last decade. However, the movement cannot maintain its present momentum without confronting some major obstacles that now lie in its path. The present chapter briefly outlines recent progress and focuses on two key interrelated challenges facing the contemporary health and human rights movement. So long as these challenges are not adequately addressed, the health and human rights movement will be unable to realize its considerable potential.

A. Recent progress

7. With a few exceptions, the relationship between health and human rights was not subject to close, serious examination until the 1990s. Of course, the World Health Organization (WHO) Constitution of 1946 affirms the right to health and so does the Declaration of Alma-Ata of 1978. Both represent very significant milestones in the journey of health and human rights. Also, some of those who were struggling against HIV/AIDS in the 1980s recognized the crucial importance of human rights. But, for the most part, these important developments were not accompanied by a detailed examination of the substantive relationship between health and human rights. That had to wait until the early 1990s, little more than a decade ago.[2] A great debt is owed to the late Jonathan Mann and his colleagues at the Harvard School of Public Health and the Francois-Xavier Bagnoud Center for Health and Human Rights for their pioneering work on the relationship between health and human rights, especially in the context of HIV/AIDS.

8. In the 1990s, however, Dr. Mann and others suffered from a serious limitation that does not apply today. At that time, although there was a widespread and detailed understanding of many human rights, there was no comparable understanding of what must surely be a cornerstone of any consideration of health and human rights: the right to the highest attainable standard of health. Inevitably, this gap placed a significant constraint on all those working in the field of health and human rights during this period. It was not until 2000 that an authoritative understanding of the right to health emerged when the Committee on Economic, Social and Cultural Rights, working in close collaboration with WHO and many others, adopted general comment No. 14.

9. Although neither complete, nor perfect, nor binding, general comment No. 14 is compelling and groundbreaking. For the first time, here is a substantive understanding of the right to health that can be made operational and improved in the light of practical experience. The general comment makes the right to health - as set out in the WHO Constitution, affirmed in the Declaration of Alma-Ata and enshrined in numerous binding international human rights treaties - more than a slogan. In short, it represents another important milestone in the journey of health and human rights.

10. Since 2000, the development of the health and human rights movement has quickened. Some States, such as Peru, have begun to take the right to health seriously at the domestic level.[3] Others, such as Sweden, are endeavouring to integrate the right to health, and other human rights, into their international policies.[4] For many years, UNICEF, UNAIDS and some other

agencies gave careful attention to human rights and, in some cases, this deepened after 2000. In 2003, for example, UNAIDS buttressed its human rights work by establishing an expert Global Reference Group on HIV/AIDS and Human Rights. Presently, UNFPA is developing a training package on a human rights-based approach with a particular focus on gender equality and reproductive rights. Within WHO, the Special Rapporteur has found willing collaborators in some areas such as neglected diseases, mental health, child and adolescent health, essential medicines and sexual and reproductive health, as well as in some regional and country offices.[5] WHO booklets *25 Questions and Answers on Health and Human Rights* (2002) and *Human Rights, Health and Poverty Reduction Strategies* (2005) remain among the most accessible introductions to these subjects.[6]

11. The present decade has also seen a growing number of health and human rights cases decided at the national, regional and international levels; a sample of this case law is provided in section III of this report. Also, the academic literature on health, human rights and the right to health has deepened, while courses that teach these issues have proliferated.[7]

B. Civil society, health and human rights

12. Since 2000, one of the most striking developments has been in civil society. Non-governmental organizations working in low- and middle-income countries have always had a clearer appreciation of health and human rights issues than their counterparts working in high-income countries. In some countries, the Special Rapporteur has been deeply impressed by civil society's commitment to, and familiarity with, the right to health. In Peru, for example, some civil society groups explicitly use human rights language, run right-to-health information campaigns, call for grass-roots participation in health policymaking, take health and human rights cases, and so on.[8] Such health and human rights activism has coincided with the publication of a range of relevant materials in all regions, such as *The Right to Health: A Resource Manual for NGOs*.[9]

13. The increased commitment of civil society organizations to economic, social and cultural rights, including the right to health, has extended beyond the national level to international NGOs. For many years, Amnesty International was associated with a narrow range of civil and political rights. More recently, its global membership decided this had to change. According to its 2005 publication *Human Rights and Human Dignity: A Primer on Economic, Social and Cultural Rights*: "In recent years Amnesty International has broadened its mission in recognition that there are many more prisoners of poverty than prisoners of conscience, and that millions endure the torture of hunger and slow death from preventable disease."[10] Moreover, this broader mission is beginning to translate into specific right-to-health initiatives.[11] Other international NGOs - Human Rights Watch, International Commission of Jurists, International Federation of Human Rights Leagues, International Service for Human Rights, Interights, and others - are also giving more attention to economic, social and cultural rights. The commitment varies from one organization to another and is often contested. Also, as argued below, much more needs to be done. Nonetheless, the general trend is unmistakeable and in the right direction.

14. Another important group of human rights NGOs is those mainly consisting of health professionals, such as Physicians for Human Rights and the International Federation of Health and Human Rights Organizations. In the 1990s, such groups tended to focus on the civil and

political rights dimension of health, such as torture issues. In recent years, this focus has widened to encompass the right to the highest attainable standard of health. A few national medical associations, such as the British Medical Association, are also giving more attention to health and human rights. In 2006, the American Public Health Association held its annual meeting on "Public Health and Human Rights".

15. Médecins Sans Frontières, Médecins du Monde, Partners in Health, Doctors for Global Health and similar organizations of health professionals are delivering health services to vulnerable individuals and communities in all regions of the world. Their practical, life-saving work is inspirational. Interestingly, their use of human rights varies a great deal. Some use human rights as an advocacy tool; others also use human rights as a way of formulating equitable health policies and programmes; while others seldom explicitly use human rights at all. The same can be said about organizations working in the field of development. CARE, for example, explicitly uses human rights in its health work.

16. Providing a bridge between many of these groups, the People's Health Movement has recently launched a global "Right to Health and Healthcare Campaign".[12]

17. In conclusion, space constraints permit only this brief, incomplete sketch of some recent developments concerning civil society, health and human rights. The civil society component of the health and human rights movement is much more dynamic today than it was only a few years ago. Although more dynamic than before, civil society's recognition of health issues as human rights issues remains uneven: strong in some countries, tenuous in others, and non-existent in many. There is an increasing recognition of the role of the right to health within the health and human rights movement. Nonetheless, civil society within the health and human rights movement could and should be doing much more, a crucial point that this section returns to shortly.

C. Operationalizing the right to health: the Special Rapporteur's contribution

18. General comment No. 14 greatly facilitates the design of rights-based approaches to health. Also, it underlines the links between the right to health and other human rights. However, although a ground-breaking document, the general comment was never intended to be a detailed guide to the operationalization of the right to health. As its name suggests, the general comment talks about the right to health in general terms.

19. Since 2003, the Special Rapporteur's reports have tried to make the right to health more specific, accessible, practical and operational. These reports have not only drawn from general comment No. 14, but also the work of other United Nations human rights treaty bodies,[13] as well as the practice of States, specialized agencies, courts and tribunals, non-governmental organizations and academics. Some of the Special Rapporteur's reports have focused on specific elements of the right to health, such as access to medicines.[14] Others have applied the right to health to specific issues, such as the health-related Millennium Development Goals.[15] Others have looked at the right to health in relation to specific groups of people, such as those with mental disabilities.[16] Also, country reports have applied the right to health to specific jurisdictions, such as Mozambique, Peru, Uganda, Romania and Sweden.[17]

20. Today, one of the most important health and human rights challenges is to enhance enjoyment of the right to health for those living in poverty. With this in mind, one of the Special Rapporteur's reports explains how consideration of the right to health would have strengthened Niger's Poverty Reduction Strategy.[18] Another sets out how policies deriving from the right to health can help Uganda in its struggle against "neglected" or tropical diseases, i.e. those diseases mostly afflicting those living in poverty.[19] The Ugandan report identifies specific, practical health initiatives, such as the development of village health teams, incentives for health workers to serve in remote communities, accessible public health information campaigns, and so on. Another report examines the migration of health professionals from developing to developed States; it shows that this skills drain is a perverse subsidy from poor to rich that further undermines the right to health of those living in poverty in the sending countries.[20] Effectively, these reports - as well as others, such as the Mozambican report[21] - are exploring how to operationalize the right to health for those living in poverty.

21. General comment No. 14 provides one paragraph on the right to health of indigenous peoples.[22] Although this paragraph is highly instructive, it only contains a few sentences. The Special Rapporteur has written three reports with sections on indigenous peoples. One section considers indigenous peoples and the right to health generally,[23] while the other two are specific to the indigenous peoples of Peru and Sweden.[24] Each chapter includes recommendations for State authorities and other actors. Effectively, all three reports are helping to operationalize the right to health of indigenous peoples.

22. Although trade impacts on the right to health in numerous ways, these issues receive very limited explicit attention in general comment No. 14. In 2004, the Special Rapporteur devoted a report to the relationship between the World Trade Organization and the right to health.[25] The report examines issues such as intellectual property in relation to access to medicines, and trade in services in relation to access to health care. Some of these issues were examined further in the Special Rapporteur's report following his country mission to Peru, specifically in relation to the United States-Peru trade agreement.[26] Both reports provide recommendations. In effect, these reports take the general principles outlined in general comment No. 14 and apply them to a number of specific trade issues, thereby helping to operationalize the right to health in relation to intellectual property, trade in services, and so on.

23. Many other examples could be given, but these three - on poverty, indigenous peoples and trade - are sufficient to signal that the Special Rapporteur's reports have focused on how the right to health can be operationalized. They have moved from the general to the specific. Of course, they do not provide detailed right-to-health programmes; this would require more space and contextualization than is possible in reports of this kind. Nonetheless, the reports identify some of the key practical features that specific right-to-health programmes should encompass.

24. The right to health is one of the most extensive and complex human rights in the international lexicon. The Special Rapporteur's reports also provide a way of "unpacking" the right to health with a view to making it easier to understand. The most detailed application of this "unpacking" is found in the report on mental disabilities.[27] While this report sets out in some detail how the right to health can be operationalized for those with mental disabilities,

additionally it provides a "map" to the right to health that is not confined to mental disabilities - it has general application. Finally, the reports also deepen and refine our conceptual understanding of some elements of general comment No. 14, such as those relating to international assistance and cooperation.

D. New skills and techniques

25. Over many years, the traditional human rights movement has developed a range of methods and techniques to further its objectives. Typically, these techniques have included, inter alia, "naming and shaming", letter-writing campaigns, taking test cases, sloganizing, and so on. These methods have served the human rights community well and they continue to be of fundamental importance, including in relation to the right to the highest attainable standard of health. But in the context of the right to health, these traditional human rights methods and techniques are no longer enough.

26. In his first report to the Commission on Human Rights, the Special Rapporteur emphasized that the right to health "should be consistently and coherently applied across all relevant national and international policy-making processes".[28] Indeed, this has been one of the primary aims of all his reports: to promote the integration of the right to health in all health-related policies. However, to achieve this aim, the traditional human rights methods and techniques are insufficient. The right to health cannot be integrated into national and international policies by merely "naming and shaming", conducting letter-writing campaigns and test cases, and uttering slogans. Today, an increasing number of participants in the health and human rights movement understand that additional methods, techniques and skills are needed if the right to health is to be operationalized through health policies, programmes and projects. Moreover, they are already developing these new approaches.

27. It is now widely recognized, for example, that a system of indicators and benchmarks is needed to measure the progressive realization of the right to health. Several specialized agencies, civil society organizations, academics and others are contributing to the development of appropriate indicators and benchmarks in the specific context of the right to health and other human rights. For his part, the Special Rapporteur has written three reports on this issue, the last of which sets out a human rights-based approach to health indicators.[29]

28. Also, a range of actors are now developing human rights - and right-to-health - impact assessments. If the right to health is to be integrated into policies, a methodology is needed to help policymakers anticipate the likely impact of a projected policy on the enjoyment of the right to health, so that, if necessary, adjustments can be made to the proposed policy. The Special Rapporteur has co-authored a UNESCO-funded paper that introduces some of the literature on this topic and sets out, for discussion, a draft methodology for right-to-health impact assessments.[30]

29. Today, the health and human rights movement is grappling with difficult questions: for example, when formulating health policies, which trade-offs are permissible and impermissible from the perspective of the right to health? Given finite budgets, how should ministers of health prioritize, in a manner that is respectful of the right to health, amongst competing objectives? Of

course, human rights do not provide neat answers to these complex issues any more than does equity, health economics or any other body of principles and knowledge. Nonetheless, the health and human rights movement is developing the techniques and skills to enable it to make a constructive contribution to these important and complex discussions.

30. In short, there is a new maturity about the health and human rights movement. "Naming and shaming", test cases and slogans all have a vital role to play in the promotion and protection of the right to health, but so do indicators, benchmarks, impact assessments, budgetary analysis, and the ability to take tough policy choices in a manner that is respectful of international human rights law and practice.

E. The pivotal role of established human rights civil society organizations

31. Earlier in this section, the Special Rapporteur argues that some established human rights NGOs are now giving more attention than before to economic, social and cultural rights, including the right to health. While this is very encouraging, the Special Rapporteur also has the firm impression that some of these organizations still devote much more attention to civil and political rights than to economic, social and cultural rights. Although there are numerous and widespread right-to-health problems that are an affront to humanity, they still seldom attract the sustained attention of established human rights NGOs.

32. Take maternal mortality. Each year, there are over 500,000 maternal deaths. That is the equivalent of about one maternal death every minute; 95 per cent of maternal deaths are in Africa and Asia. Most could be avoided by a few well-known interventions. While women in some rich countries have a 1 in 8,700 chance of dying in childbirth, women in some low-income countries have a 1 in 10 chance.

33. These facts are especially shocking not only because they are preventable, but also because they expose profound health inequalities. First, the burden of maternal mortality falls disproportionately on women in developing countries. Second, in both developing and developed countries, the burden of maternal mortality falls disproportionately on ethnic minority women, indigenous women and women living in poverty. Third, there is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal mortality and morbidity. In other words, maternal mortality and morbidity reveal sharp discrepancies between men and women in their enjoyment of sexual and reproductive health rights. In summary, maternal mortality highlights multiple inequalities - global, ethnic and gender. And recurring throughout is the entrenched disadvantage of those living in poverty.

34. As the Special Rapporteur argued in his last report to the General Assembly, maternal mortality is not just a health issue, it is a human rights issue.[31] Avoidable maternal mortality violates women's rights to life, health, equality and non-discrimination. Moreover, the scale of maternal mortality is just as large as - if not larger than - many of the extremely serious human rights issues that, for many years, have attracted much of the attention of established human rights NGOs. For example, several of these organizations campaign against the death penalty. In 2005, about 2,500 people under sentence of death were executed.[32] This is almost certainly an underestimate, so assume this figure might be multiplied tenfold to 25,000. How many maternal deaths were there in the same period? About 500,000.

35. Since 1980, the Working Group on Enforced or Involuntary Disappearances has taken up about 50,000 cases.[33] How many maternal deaths were there in this 26-year period? Well over 10 million. Certainly, the number of disappearances in this period far exceeds 50,000, but nobody suggests that the number approaches 10 million. Despite this, disappearances have generated their own "special procedure" (the Working Group), various international instruments on this specific human rights issue,[34] and the relentless attention of many civil society organizations.

36. The death penalty and disappearances are extremely serious human rights issues that fully deserve the human rights attention they have received. But maternal mortality is also an extremely serious human rights problem and it has not received the attention from the human rights community that it deserves. In fact, with a few notable exceptions, maternal mortality has received virtually no attention from the mainstream human rights community.

37. Last year, a number of world leaders - Bill Clinton, Fernando Henrique Cardoso, Desmond Tutu, Mary Robinson, Gro Brundtland, Nafis Sidik and many others - adopted a Leaders' Call to Action on the right to health.[35] In this spirit, the time has come for established human rights NGOs to recognize that maternal mortality is a human rights catastrophe on a massive scale. They must campaign against maternal mortality, and other egregious health and human rights issues, just as vigorously as they have taken up the death penalty, disappearances, extrajudicial executions, torture, arbitrary detention and prisoners of conscience. If they decline to do this, then profoundly important health and human rights issues will never become part of the human rights mainstream.

F. The pivotal role of health professionals

38. Here the term "health professionals" is used to encompass all those working in the fields of medical care and public health, including health community workers, policymakers, economists and administrators.

39. The Special Rapporteur has submitted over 20 reports on the right to the highest attainable standard of health, and these reports repeatedly confirm the common ground shared between those professionals working in health and those working in human rights. Both groups wish to establish effective, integrated, responsive health systems accessible to all. Both stress the importance not only of access to health care, but also access to water, sanitation, health information and education. Both understand that good health is not the sole responsibility of the Ministry of Health, but a wide range of public and private actors. Both prioritize the struggle against discrimination and disadvantage and both stress cultural respect. At root, those working in health and human rights are both animated by a similar concern: the well-being of individuals and populations.

40. Moreover, these reports not only confirm that health and human rights occupy much common ground; they also show how health and human rights complement and reinforce each other.

41. Obviously, the realization of the right to the highest attainable standard of health depends upon health professionals enhancing public health and delivering medical care. The right to

health cannot be realized without health professionals. Equally, the classic, traditional objectives of the various health professions can benefit from the new, dynamic discipline of human rights. Human rights can help to reinforce existing, good health programmes, and they can sometimes help to identify new, equitable health policies. They can help to ensure that health policies and programmes are equitable, effective, evidence-based, robust, participatory, inclusive and meaningful to those living in poverty. The supportive role of human rights extends to the provision of medical care, as well as public health. Also, provided it is done in an appropriate manner, framing a pressing health concern as a human rights issue can enhance its legitimacy and importance. In other words, health professionals can use human rights to help them achieve their professional objectives.

42. Health professionals run the key international health organizations, as well as ministries of health across the globe. Naturally, they dominate the health sector, both public and private. Clearly, there is no possibility of putting the right to health - and other health-related rights - into practice without large numbers of well-positioned health professionals understanding and supporting this endeavour. In short, there is no chance of operationalizing the right to health without the active engagement of many health professionals.

43. Here, however, is a very major problem. To be blunt, most health professionals whom the Special Rapporteur meets have not even heard of the right to health. If they have heard of it, they usually have no idea what it means, either conceptually or operationally. If they have heard of it, they are likely to be worried that it is something that will get them into trouble. The problem is partly one of language: while health and human rights have much in common, the language used is often different. That is one of the reasons why the Special Rapporteur is presently completing a short paper on the complementary relationship between equity (a term familiar to many health professionals) and human rights.

44. Earlier in this section, the Special Rapporteur argues that some health professionals have recently begun to take human rights, including the right to health, more seriously. This is undoubtedly true and very encouraging. However, if further progress is to be made towards the operationalization of the right to health, many more health professionals must begin to appreciate the human rights dimensions of their work. The message must be conveyed much more clearly and widely that the right to health, and other health-related rights, are allies and assets for health professionals to use. Health professionals can use health-related rights to help them devise more equitable policies and programmes; to place important health issues higher up national and international agendas; to secure better coordination across health-related sectors; to raise more funds from the Treasury; to leverage more funds from developed countries to developing countries; in some countries, to improve the terms and conditions of those working in the health sector; and so on. It is crucial that many more health professionals come to appreciate that the right to the highest attainable standard of health is not just a rhetorical device, but also a tool that can save lives and reduce suffering, especially among the most disadvantaged.

45. Listening to those health professionals who disregard the potential of human rights to assist their work, it sometimes becomes clear that they do not understand some elementary features of the right to the highest attainable standard of health. Some do not appreciate that the right to health is subject to progressive realization (of course a State is not expected to realize the right immediately). Others do not grasp that the right to health is subject to resource availability

(of course what is required from Canada is more than what is required from Chad).[36] Some do not understand that the right to health encompasses both health care and the underlying determinants of health, such as adequate water and sanitation. Some misinterpret human rights and then argue that they are contrary to "social equity" whereas precisely the reverse is true. Frequently, they are only aware of the traditional human rights methods and techniques, such as "naming and shaming", and they fail to appreciate that the maturing health and human rights movement is developing the more sophisticated techniques signalled in the previous section.

46. One of the areas where there is often a serious misunderstanding is accountability. Although human rights demand accountability, that does not mean everybody working in health and human rights has the task of holding duty-bearers to account; it does not mean that every health professional or specialized agency becomes a human rights enforcer. What it means is that there must be accessible, transparent and effective mechanisms of accountability in relation to health and human rights. The health and human rights movement needs human rights advisers, implementers and enablers, as well as those whose job it is to hold duty-bearers to account. All these functions will rarely reside in one organization or person. While specialized agencies should be human rights advisers, implementers and enablers, it is not their primary job to hold States to account. The accountability function must be provided by some organization or person, but not by a specialized agency, unless the agency decides to establish a discreet independent procedure and body for this purpose.[37] Accountability is also sometimes narrowly understood to mean blame and punishment, whereas it is more accurately regarded as a process to determine what is working (so it can be repeated) and what is not (so it can be adjusted).

47. It would be unfair to reproach those health professionals who are unfamiliar with the right to health and other human rights. It is not their fault if they have not been exposed to the potential of human rights to reinforce their work. In most countries, health professionals can qualify and practice without being taught anything about human rights. It is for this reason that in one of the Special Rapporteur's earliest reports he devoted a section to the importance of deepening human rights education for health professionals.[38]

G. Conclusion

48. This section briefly signals some of the progress made by the health and human rights movement in the last decade. The movement has come a long way in a short time. While there is still much further to travel, the key pieces are now in place for the health and human rights movement to flourish in the next few years.

49. However, the movement is confronted with a range of major obstacles, such as inadequate budget support for the health sector, as well as the continuing resistance of the present Government of the United States of America to economic, social and cultural rights, including the right to the highest attainable standard of health. When a Government as influential as that of the United States is unsupportive of a particular human right, it is much more difficult for relevant United Nations agencies to advance this agenda, even when the right in question forms part of the organization's constitution.

50. In recent years, WHO has contributed to the health and human rights movement, as briefly acknowledged in paragraph 10 of this report. Unfortunately, however, neither the member States nor the Secretariat of WHO has provided leadership in this field. The 2005 World Summit urged the "mainstreaming of human rights throughout the United Nations system", reaffirming a vital component of the Secretary-General's reform package adopted in 1997.[39] But this has not happened within WHO, where the health and human rights agenda has remained marginal, contested and severely under-resourced. This is deeply regrettable because human rights can reinforce, sharpen and invigorate the health policies, programmes and projects of WHO and its member States. The programme of work for 2006-2015 recently adopted by WHO includes seven priority areas, including the promotion of health-related rights. It will be interesting to monitor how this important feature of the WHO programme is implemented.

51. This section, however, focuses on two related obstacles: the inadequate engagement of established human rights NGOs, as well as health professionals, in the health and human rights movement. The section's main aim is to draw attention to these twin obstacles so that collective consideration can be given to how they might be dismantled. A few preliminary observations, however, are in order about what steps might be taken in relation to the second obstacle, concerning health professionals.

52. As the Special Rapporteur argues in an earlier report, States should build an environment that supports the adoption of rights-based approaches by the health community.[40] All bodies responsible for the training of health professionals should integrate human rights education and training at all professional levels. National health professional associations should raise awareness about human rights and stimulate demand for human rights education among their members. The staff of ministries of health, as well as those working in health-related sectors, should become familiar with the complementary relationship between health and human rights. National human rights institutions should provide human rights training for health professionals. Human rights training institutions should include health-related rights in their curricula.

53. WHO has a critical role to play. As a priority, the Secretariat should develop, through broad ranging consultations with member States and other stakeholders, a strategy setting out its mandate, role and priority activities in the area of health and human rights, including national capacity-building. This strategy should be submitted to, and approved by, the WHO governing bodies. Such a strategy will provide WHO with a solid institutional platform for its work in this area of increasing promise and interest. In turn, this will lead to a more systematic application of a human rights-based approach in countries.

54. For their part, those already committed to health-related rights should not overstate the contribution of human rights; after all, human rights do not provide magic solutions to complex health problems. Nonetheless, human rights have a constructive contribution to make - and this contribution cannot be realized without the active support and engagement of large numbers of health professionals.

III. CASES ON THE RIGHT TO HEALTH AND OTHER HEALTH-RELATED RIGHTS

A. Introduction

55. Because the right to the highest attainable standard of health is so extensive and complex, a top priority is to clarify the scope of the right to health and other health-related rights. There are several ways of doing this, including through the case law of bodies with responsibility for interpreting human rights. This section includes a sample of cases that signal what various national, regional and international tribunals understand health-related rights to mean.

56. Some of the cases interpret the right to the highest attainable standard of health in terms of either the right to health care (e.g. access to emergency medical treatment), or the underlying determinants of health (e.g. access to uncontaminated food). Both dimensions of the right to health are crucial. Some of the cases rely upon health-related rights (e.g. the right to life) where interpreted by the courts to protect health. Although the right to health is enshrined in an increasing number of constitutions, even more jurisdictions recognize health-related rights. Some of the cases rely upon both the right to health and other health-related rights.[41]

57. Unless supported by some form of accountability, human rights run the risk of becoming mere window dressing. There are many forms of accountability. While some are general (e.g. fair elections, a free press), others are specific to human rights (e.g. inquiries by national human rights institutions). While some are judicial (e.g. bills of rights enforceable in the courts), others are administrative (e.g. human right impact assessments). While some are national (e.g. a constitutional court), others are international (e.g. a human rights treaty body). Within each State there will have to be a range of accountability mechanisms. Just as the forms of accountability are likely to vary from one State to another, so will the appropriate mix. All mechanisms of accountability should be accessible, transparent and effective.

58. This chapter focuses on just one form of accountability: judicial accountability. The limitations of judicial processes are well known. However, as the following cases illustrate, courts can clarify the meaning of health-related rights and also secure better health-related services for individuals and communities. The cases are broadly grouped under some of the key concepts found in international human rights law.[42]

B. Progressive realization, resource availability and immediate obligations

59. According to international - and some national - human rights law, the right to the highest attainable standard of health is subject to progressive realization and resource availability.[43] Put simply, progressive realization means that States are expected to do better next year than they are doing today, while resource availability acknowledges that what is required of a rich country is of a higher standard than what is required of a low - or middle-income country.

60. The Constitution of South Africa includes a Bill of Rights that recognizes the right of access to health-care services.[44] According to the Bill of Rights, the State is required to take reasonable measures, within its available resources, to achieve the progressive realization of this human right. The case of *Minister of Health v. Treatment Action Campaign* concerned State

provision of Nevirapine, an antiretroviral drug used to prevent mother-to-child-transmission (MTCT) of HIV.[45] Applying the concepts of progressive realization and resource availability, the Constitutional Court confirmed that the Government must "act reasonably to provide access to the socio-economic rights identified in the Constitution on a progressive basis" and it ordered the authorities to "devise and implement, within its available resources, a comprehensive and co-ordinated programme to recognise progressively the rights of pregnant women and their new-born children to have access to health services to combat MTCT of HIV". This case is discussed in more detail in paragraph 72.

61. The South African Constitutional Court also reflected on the issue of resource availability in the case *Soobramoney v. Minister of Health KwaZulu Natal.*[46] The applicant suffered from chronic renal failure and required dialysis to survive. His condition was diagnosed as irreversible. While he was initially able to pay for private treatment, he ran out of funds and sought treatment in a State-funded hospital. Due to its limited resources, the hospital was not able to provide dialysis to all patients. The hospital had therefore adopted a policy and guidelines regarding access to dialysis. Only patients who suffered from acute renal failure, which can be treated and remedied by dialysis, were automatically entitled to treatment. For patients suffering from chronic renal failure, the primary requirement for admission to the dialysis programme was eligibility for a kidney transplant. Patients also suffering from significant vascular or cardiac diseases were not eligible for a transplant. Mr. Soobramoney failed to satisfy the hospital requirements for dialysis.

62. The Bill of Rights provides: "No one may be refused emergency medical treatment."[47] In Mr. Soobramoney's case, had the hospital violated this provision of the Bill of Rights? The Court held that it had not because the patient was not an "emergency" in the sense of a sudden catastrophe; rather, his condition was an "ongoing state of affairs". As already noted in the *Treatment Action Campaign* case, however, the Bill of Rights also includes a right of access to health-care services, requiring the State to take reasonable measures, within available resources, to achieve the progressive realization of this human right. In *Soobramoney*, the Constitutional Court found that the hospital's policy and guidelines were reasonable and fairly applied, and it held that the failure to provide treatment did not violate the Bill of Rights in this case.

63. While many elements of the right to the highest attainable standard of health are subject to progressive realization and resource availability, the right also gives rise to some obligations of immediate effect that are subject to neither. Equal treatment of women and men, for example, is not subject to progressive realization and resource availability. A State may not argue that presently it has insufficient resources to provide equal services for women and men and so, for the time being, it is going to focus on services for men, but it will progressively make available the same services for women over the next few years just as soon as the necessary funds become available. As the next case shows, some courts have held that other elements of the right to health also give rise to immediate obligations that are subject to neither progressive realization nor resource availability.

64. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal,* the Supreme Court of India held that the Government could not escape its responsibility, on account of financial constraints, to provide emergency treatment.[48] In this case, a man fell from a train and suffered serious head trauma. He was taken to a number of State hospitals but none was able to provide

him with emergency treatment; they lacked bed space, as well as trauma and neurological services. The issue before the Court was whether inadequate medical facilities for emergency treatment constituted a denial of the right to life.

65. The Court found that it was the duty of a State to ensure that medical facilities for emergency treatment were adequately available. It required the State to ensure that primary health centres were equipped to provide immediate stabilizing treatment for serious injuries and emergencies. In addition, the Court ordered the State to increase the number of specialist and regional clinics around the country available to treat serious injuries, and to create a centralized communication system among State hospitals so that patients could be transported immediately to the facilities where space is available. The Court recognized that substantial expenditure was needed to ensure that medical facilities were adequate. However, it held that "a State could not avoid this constitutional obligation on account of financial constraints".

66. At the end of this section, the Special Rapporteur confines himself to two remarks. First, progressive realization does not mean that a State is free to adopt any measures that are broadly going in the right direction. States have a legal obligation to take "deliberate, concrete and targeted" steps towards the realization of the right to health for all.[49] Health research and experience confirm that some measures work better than others. States are obliged to take those measures that are the best available to them.

67. Second, *Samity* confirms that there are health-related rights that give rise to some immediate obligations that are not subject to resource availability. More work needs to be done to clarify what these immediate obligations are in the health context. However, if a Government of a low-income country has insufficient resources to meet its immediate health-related obligations, it is incumbent upon those in a position to assist to provide international assistance and cooperation that will enable the Government to meet its immediate obligations.[50]

C. Available, accessible, acceptable and of good quality

68. Health facilities, goods and services must be available, accessible, acceptable and of good quality, as illustrated by the following cases.[51] The precise practical application of these requirements - available, accessible and so on - may vary from one country to another depending upon, for example, resource availability.

1. Available

69. The right to health requires functioning health facilities, goods and services to be available in sufficient quantity throughout a State.

70. In the case of *Mariela Viceconte v. Ministry of Health and Social Welfare,* Mariela Viceconte, and the National Ombudsman, asked the court to order the Government of Argentina to take protective measures against haemorrhagic fever which threatened 3.5 million people.[52] More specifically, they asked the court to order the Government to produce a WHO certified vaccine (Candid-1) for Argentine haemorrhagic fever. According to the court, it was the Government's responsibility to make health care available in a situation where the existing health-care system, including the private sector, was not protecting individuals' health. In light

of the Constitution's incorporation of international treaties that recognize the right to health, the court found that the Government had not "fulfilled its obligations to make available the Candid-1 vaccine". Because the private sector saw the production of the vaccine as unprofitable, the court ordered the State to produce Candid-1.

2. Accessible

71. The right to health imposes an obligation on a State to ensure that health facilities, goods and services are accessible to everyone within its jurisdiction. In this context, access has four main dimensions: the facilities, goods and services must be physically accessible; economically accessible (i.e. affordable); and accessible without discrimination; also, health information must be accessible.[53]

72. In *Minister of Health v. Treatment Action Campaign*, as well as considering the issue of resource availability and progressive realization (see paragraph 60), the South African Constitutional Court also considered whether or not Nevirapine was accessible.[54] The Government provided Nevirapine at only two research and training sites per province. The drug could also be obtained from private medical providers. As a result, mothers and their babies who did not have access to the research and training sites, and who could not afford access to private health care, were unable to gain access to Nevirapine. The Government argued that "until the best programme has been formulated and the necessary funds and infrastructure provided … the drug must be withheld from mothers and children who do not have access to the research and training sites". However, the Court held that the State's limited provision of Nevirapine was unreasonable. It ordered that the Government act without delay to provide, inter alia, the drug in public hospitals and clinics when medically indicated.[55]

73. States must take reasonable measures to enhance access to health information, including for people with disabilities. In the Canadian case of *Eldridge v. British Columbia*, a group of deaf applicants challenged the absence of sign-language interpreters in the publicly funded health-care system.[56] The Supreme Court held that provincial governments had a positive obligation under the Canadian Charter of Rights and Freedoms to address the needs of disadvantaged groups, such as persons with disabilities. The Court decided that the applicants had a right to publicly funded sign-language interpretation in the provision of health care and that the failure of the authorities to ensure that the applicants benefited equally from the provincial medicare scheme amounted to discrimination.

3. Acceptable

74. The right to health requires that all health facilities, goods and services must be respectful of medical ethics, such as the requirements of informed consent, and be culturally appropriate. In *Andrea Szijjarto v. Hungary*, a Hungarian woman of Roma origin alleged that she had been coercively sterilized.[57] In 2000, she went into labour and was taken to hospital. Upon examination, it was found that the foetus had died and a Caesarean section was urgently needed. On the operating table, she was asked to sign a form consenting to the Caesarean section, as well as a "barely legible note" handwritten by the doctor giving permission for sterilization. The reference to sterilization was in a language that she did not understand. In her application to the Committee on the Elimination of Discrimination against Women, she alleged that this conduct

constituted a violation of her right to appropriate health-care services, as well as her right to decide freely and responsibly on the number and spacing of her children. The Committee decided that Hungary had failed to provide Andrea with appropriate information and advice on family planning and ensure that Andrea had given her fully informed consent to the operation and it recommended that the Government provide the applicant with appropriate compensation.

4. Good quality

75. Health facilities, goods and services must be scientifically and medically appropriate and of good quality. The Supreme Court of Bangladesh considered this requirement in *Dr. Mohiuddin Farooque v. Bangladesh*.[58] Dr. Farooque challenged the failure of the authorities to take effective measures to deal with a large consignment of imported skimmed milk powder that contained radioactive material. The court found that the contaminated powder was a threat to health and thereby gave rise to a breach of the right to life under the Constitution.[59] Through an interpretation of a constitutional provision that requires the State to improve the quality of health and nutrition,[60] the court interpreted the right to life to include, among others, the "protection of health and normal longevity of an ordinary human being". The court ordered the Government to test the consignment's radiation level.

76. At the end of this section, the Special Rapporteur makes two observations. First, it will be recalled that some of the requirements signalled in the previous paragraphs have to be understood in the context of resource availability. The right to health demands better access to a wider range of medicines in high-income than in low-income countries. In Canada, sign-language interpretation for the deaf is required (*Eldridge*), but in a low-income country less costly measures to enhance access for those with disabilities will be acceptable. Second, not all elements of the right to health demand many resources. The *Szijjarto* case demanded respectful treatment, *Farooque* required quality controls on food imports, *K.L. v. Peru* (see next section) could be addressed by appropriate guidelines, and so on. Even with very limited resources, there is much that States can do to realize the right to the highest attainable standard of health.

D. The duties to respect, protect and fulfil

77. Human rights place duties on States to respect, protect and fulfil. Thus, States have duties to respect, protect and fulfil the right to the highest attainable standard of health.[61]

1. Respect

78. The duty to respect requires the State to refrain from denying or limiting equal access for all persons, including prisoners, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services.[62]

79. The case of *D. v. United Kingdom* concerned the proposed deportation by the British authorities of a man dying from AIDS to St. Kitts, his country of origin.[63] D. had been diagnosed with HIV while in a British prison. He applied for permission to remain in the United Kingdom after the end of his prison sentence on compassionate grounds. His deportation to St. Kitts would entail a loss of the medical treatment he was receiving. The European Court of Human Rights found that "the abrupt withdrawal of medical treatment caused by the

deportation of D. to St. Kitts would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment".[64] The Court ordered that D. should not be deported.[65]

80. *K.L. v. Peru* concerned a 17-year-old Peruvian who was denied a therapeutic abortion.[66] When K.L. was 14 weeks pregnant, doctors at a public hospital in Lima diagnosed the foetus with anencephaly, a foetal abnormality that would endanger K.L.'s health if pregnancy continued. Under Peru's Criminal Code, therapeutic abortion is permissible when necessary to safeguard the life or health of the woman. However, K.L. was denied a therapeutic abortion by the director of the hospital. She was compelled to carry the foetus to term and forced to feed the baby until his inevitable death several days after birth. According to K.L., Peru's failure to respond to the reluctance of some of the medical community to comply with the legal provision authorizing therapeutic abortion violated the International Covenant on Civil and Political Rights. The Human Rights Committee held that, by denying the complainant's request to undergo an abortion in accordance with the Peruvian Criminal Code, the Government was in breach of its obligations under the Covenant.[67] The Committee decided, inter alia, that the Government must take steps to prevent the future occurrence of similar violations. The Special Rapporteur adds that one way for the Government to conform to its existing obligations under the Criminal Code is to provide clear, appropriate guidance to health professionals about when a therapeutic abortion is lawful and should be available.

81. In *Yanomami v. Brazil*, the applicants claimed that the construction of a highway and exploitation of resources on their traditional lands, and the resulting damage to their environment and traditional way of life, violated the American Declaration of the Rights and Duties of Man.[68] They claimed that the road building displaced them from their ancestral lands and that many of their people died from influenza, tuberculosis, measles, venereal diseases and other epidemics arising from the project. The Inter-American Commission on Human Rights established a link between environmental quality and the right to life, and held that the failure of the Government to provide the Yanomami with an alternative site to live in amounted to a violation of their rights to life, liberty and personal security. The Commission recommended that "the Government of Brazil continue to take preventive and curative health measures to protect the lives and health of Indians exposed to infectious or contagious diseases".

2. Protect

82. The duty to protect requires States to take measures that prevent third parties (e.g. private companies) from interfering with the right to the highest attainable standard of health.[69]

83. In *Ratlam Municipality Council v. Vardi Chand*, the Supreme Court of India held that municipalities had a duty to protect the environment in the interests of public health.[70] The Court found that "pollutants being discharged by big factories … [are] a challenge to the social justice component of the rule of law". The Court found that the preservation of public health, premised on the decency and dignity of individuals, was a non-negotiable facet of human rights requiring State action.

84. Another case with an environmental dimension is *Social and Economic Rights Action Center and Center for Economic and Social Rights v. Nigeria*.[71] Members of the Ogoni community in Nigeria alleged that the military Government had violated their rights to health

and a clean environment, as well as several other human rights, by facilitating the operations of oil companies in Ogoniland. The applicants alleged that the operations of an oil consortium, comprising the Nigerian National Petroleum Company and Shell Petroleum Development Corporation, had contaminated the environment, leading to serious and widespread health problems among the Ogoni people. The African Commission on Human and Peoples' Rights held that the Ogoni had suffered violations of a number of their human rights, including their rights to health and a clean environment, as a result of the Government's failure to prevent pollution and ecological degradation. It found that the Government had failed to adequately regulate and monitor the oil consortium. The Commission issued a number of orders, for example, environmental and social impact assessments should be prepared in the future and health and environmental information should be made available.

3. Fulfil

85. The duty to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of the right to health.[72]

86. In *Purohit and Moore v. The Gambia*, mental health advocates witnessed the inhuman treatment of mental health patients in the psychiatric unit of the Royal Victoria Hospital in the Gambia.[73] They submitted a complaint to the African Commission on Human and Peoples' Rights on behalf of the mental health patients detained in the unit. The principal legislation governing mental health in the Gambia was the Lunatics Detention Act (1917). The complaint pointed out that, from the human rights perspective, this colonial legislation was seriously deficient in numerous respects. The Commission held that the legislation was "lacking in terms of therapeutic objectives"; it was also inadequate to treat only those persons with mental disabilities for whom there were "matching resources and programmes". The Commission ordered the Government to replace, as soon as possible, the Lunatics Detention Act with a new legislative scheme for mental health that was compatible with the African Charter on Human and Peoples' Rights, as well as more specific international standards for the protection of persons with disabilities.

E. Conclusion

87. These cases illustrate the indispensable role of accountability. Without accountability, a State could use progressive realization and the scarcity of resources as an excuse to do virtually nothing - or to respond to whichever interest group has the loudest voice. Independent, effective and accessible mechanisms of accountability compel a State to explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all.

88. Courts are usually reluctant to intervene. They tend to give the State a wide "margin of discretion". They are well practised in striking balances between competing interests in a principled but pragmatic way: in the *Treatment Action Campaign* case, the Constitutional Court held that the Government was not doing all it reasonably could, while in *Soobramoney* the same Court declined to intervene because the hospital had a fair policy in place. Supported by appropriate legislation, courts can ensure that the interests of the poor and disadvantaged - so often overlooked - are given due weight. In appropriate cases, they have the crucial

responsibility of saying that the State could be doing better and requiring it to try again. Of course, courts are not a panacea; for example, sometimes authorities are slow to comply with court orders. Nonetheless, as one form of accountability, courts have a significant role to play in the promotion and protection of health-related rights.

89. While this section signals only a few of the many health-related cases that have been decided in recent years, in early 2007 WHO, with the support of the Emory University Institute of Human Rights in the United States, will launch a database that will include information on many other national and international health-related cases concerning human rights.[74]

IV. CONCLUSIONS

90. **In 2006, the Special Rapporteur explained to the Human Rights Council that, working in close collaboration with others, he hoped to have sufficient resources to identify and examine the key features of a health system that were reflective of the international human right to health (see E/CN.4/2006/48, para. 21). In the interactive dialogue following the presentation of his report, the Special Rapporteur was encouraged to take this idea forward. Although the subject is extremely ambitious and his resources equally limited, the Special Rapporteur is trying to respond to this interest by beginning to explore this challenging issue.**

91. **The right to the highest attainable standard of health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all (see ibid., para. 4). More specifically, however, when looking at a health system from the right-to-health perspective, what are the key components that need to be present? For example, from a human rights perspective a health system will have to include an adequate system for the collection of health data; otherwise, it will be impossible for the State, or any other interested party, to monitor the progressive realization of the right to health. Moreover, the data must be disaggregated on certain grounds, such as sex, age and urban/rural, otherwise it will be impossible to monitor the progressive realization of the right to health in relation to vulnerable populations, such as women, children and those living in remote rural communities (see ibid., para. 49 (b)).**

92. **Also, from the right-to-health perspective, a health system will have to include a national capacity to produce a sufficient number of well-trained health workers who enjoy good terms and conditions of employment; a process for the preparation of right-to-health impact assessments before major health-related policies are finalized; arrangements for ensuring, as much as possible, "bottom-up" participation in the formulation of health policies; effective, transparent and accessible mechanisms of accountability; and so on.**

93. **These are some of the issues that the Special Rapporteur is beginning to explore with a view to identifying some of the key features of a health system from the right-to-health perspective. He invites others to support and collaborate with him in this very major undertaking and he hopes to have the opportunity to report further to the Council as this work unfolds.**

Annex

NOTES TO THE REPORT

[1] In the framework of his mandate, the Special Rapporteur also participated in a range of additional meetings and workshops between September and December 2006. For example, he participated as an instructor on the course "Monitoreando el Derecho a la Salud en América Latina", held in Lima, Peru, and organized by EdhucaSalud and the International Federation of Health and Human Rights Organizations (IFHHRO). He was also a keynote speaker at the conference, "Exclusión y Derecho a la Salud: La Función de los Profesionales de la Salud", which was also organized by EdhucaSalud and IFHHRO and held in Lima. Whilst in Peru, he co-organized an informal consultation on maternal mortality and human rights, together with CARE; CARE Peru; the Averting Maternal Death and Disability Program, Mailman School of Public Health; and the Human Rights Centre, University of Essex. He presented a paper at the conference, "Welfare Rights: in Theory and Practice", held at Oxford University. He spoke at the Annual Meeting of the American Public Health Association on "Human Rights and Public Health: At the Crossroads". He participated at a meeting on population and the Millennium Development Goals organized by the London School of Hygiene and Tropical Medicine and the Population and Sustainability Network. The Special Rapporteur also spoke at a seminar in Belfast organized by the Participation and the Practice of Rights Project, on "Making and Measuring Change-A Human Rights Based Approach to Health". He also participated in a conference in Cairo organized by the Egyptian National Council on Human Rights on "The Right to Development: 20 Years After, What's Next?".

[2] For an early examination of the linkages between human rights and HIV/AIDS see K. Tomasevski, S. Gruskin, Z. Lazzarini and A. Hendricks, "AIDS and Human Rights" in J. Mann, D. Tarantola and T. Netter (eds), AIDS in the World, Harvard University Press, 1992, pp. 538-573.

[3] It remains to be seen whether or not the new Government, established in mid-2006, maintains this commitment.

[4] *Shared Responsibility: Sweden's Policy for Global Development,* Government Bill 2002/03:122.

[5] In an especially welcome development, a few WHO country offices have appointed Health and Human Rights Officers.

[6] For more on WHO, see the Conclusion to this chapter.

[7] Recent contributions to the academic literature include S. Gruskin, M. Grodin, G. Annas, S. Marks (eds), *Perspectives on Health and Human Rights*, 2006; A. Yamin, *The Future in the Mirror: Incorporating Strategies for the Defence and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda*, 27 (4) Human Rights Quarterly 2005; J. Ruger, *Towards a Theory of a Right to Health: Capability and Incompletely Theorized Arguments*, 18 Yale Journal of Law and the Humanities 2006.

[8] For example, see CARE Peru's project *Improving Health for the Poor: A Human Rights Approach*, http://www.care.org/careswork/projects/PER097.asp.

[9] J. Asher, *The Right to Health: A Resource Manual for NGOs*, 2004.

[10] Amnesty International, *Human Rights for Human Dignity: a Primer on Economic, Social and Cultural Rights*, 2005, p. 5.

[11] In 2006, for example, Amnesty published a study on maternal and infant health in Peru, drawing upon the right to the highest attainable standard of health, *Perú: Mujeres pobres y excluidas: le negación del derecho a la salud materno-infantil*, 2006.

[12] See http://phmovement.org/.

[13] Committee on the Rights of the Child, general comments Nos. 3 and 4; Committee on the Elimination of Discrimination against Women, general recommendation No. 24.

[14] 13 September 2006, A/61/338.

[15] 8 October 2004, A/59/422.

[16] 10 February 2005, E/CN.4/2005/51.

[17] 4 January 2005, E/CN.4/2005/51/Add.2; 4 February 2005, E/CN.4/2005/51/Add.3; 19 January 2006, E/CN.4/2006/48/Add.2; 21 February 2005, E/CN.4/2005/51/Add.4. At the time of writing, the report on Sweden has not yet been assigned a UN document number.

[18] 16 February 2004, E/CN.4/2004/49.

[19] 19 January 2006, E/CN.4/2006/48/Add.2.

[20] 12 September 2005, A/60/348.

[21] 4 January 2005, E/CN.4/2005/51/Add.2.

[22] Committee on Economic Social and Cultural Rights (CESCR), general comment No. 14, para. 27.

[23] 8 October 2004, A/59/422.

[24] 4 February 2005, E/CN.4/2005/51/Add.3. At the time of writing, the report on Sweden has not yet been assigned a UN document number.

[25] 1 March 2004, E/CN.4/2004/49/Add.1.

[26] 4 February 2005, E/CN.4/2005/51/Add.3; Press Release: US-Peru Free Trade, 13 July 2005 and 5 July 2004, available at www.unhchr.ch.

[27] 10 February 2005, E/CN.4/2005/51.

[28] 13 February 2003, E/CN.4/2003/58, para 8.

[29] 3 March 2006, E/CN.4/2006/48.

[30] Gillian MacNaughton and Paul Hunt, *Impact Assessments, Poverty and Human Rights*: *A Case Study Using the Right to the Highest Attainable Standard of Health*, 2006, available at http://www2.essex.ac.uk/human_rights_centre/rth/.

[31] 13 September 2006, A/61/338.

[32] Amnesty International, *Facts and Figures on the Death Penalty*. http://web.amnesty.org/pages/deathpenalty-facts-eng.

[33] 27 December 2005, E/CN.4/2006/56, para. 9.

[34] Such as the Inter-American Convention on Forced Disappearance of Persons (1994).

[35] Launched in December 2005, the Leaders' Call to Action can be accessed at http://www.realizingrights.org.

[36] At least in the short term.

[37] As the International Labour Organization has chosen to do.

[38] 12 September 2005, A/60/348.

[39] 2005 World Summit Outcome, A/RES/60/1, para. 126.

[40] See 12 September 2005, A/60/348.

[41] Some of the cases raise issues that go beyond health. This chapter, however, is confined to the health dimensions of the cases.

[42] Some cases could properly be located in more than one group. For example, *Samity* is not only an example of a case that gives rise to immediate obligations, it also illustrates how States have a duty to make health services available.

[43] See, for example, article 2 (1) ICESCR and article 27 (2) Constitution of South Africa.

[44] Constitution of South Africa, 1996, art. 27.

[45] CCT 8/02, full judgment available at http://www.law-lib.utoronto.ca/diana/TAC_case_study/MinisterofhealthvTACconst.court.pdf.

[46] 1998 (1) SA 765 (CC), full judgement available at http://www.law-lib.utoronto.ca/diana/TAC_case_study/Soobramoney.pdf.

[47] In accordance with section 27 (3) of the South African Constitution, 1996.

[48] 1996 SCJ 25, p. 29.

[49] CESCR, general comment No. 3, para. 2, and general comment No. 14, para. 30.

[50] CESCR, general comment No. 14, para 45; Poverty Statement adopted by the Committee on Economic, Social and Cultural Rights on 10 May 2001, E/C.12/2001/10; A. Chapman and S. Russell (eds), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Intersentia, 2002.

[51] CESCR, general comment No. 14, para. 12.

[52] Case No. 31.777/96 (1998), For a further discussion of the case see Abramovich "Argentina: The Right to Medicines" in *Litigating Economic, Social and Cultural Rights*: *Achievements, Challenges and Strategies* (COHRE 2003).

[53] Subject to the confidentiality of personal health data.

[54] CCT 8/02, full judgement available at http://www.law-lib.utoronto.ca/diana/TAC_case_study/MinisterofhealthvTACconst.court.pdf.

[55] *AIDS Access Foundation v. Bristol-Myers Squibb* is another case on economic access. The AIDS Access Foundation, and two patients living with AIDS, alleged that Bristol-Myers Squibb and the Thai Department of Intellectual Property had "conspired to intentionally delete" the dose restriction in a patent application for didanosine. They argued that this could have the effect of restricting access to this particular HIV treatment. In its judgement, the Thai Central Intellectual Property and International Trade Court ruled that, because pharmaceutical patents may lead to high prices that limit access to medicines, patients may challenge their legality. The Court asserted the primacy of human life in trade agreements, as recognized internationally by the Doha Declaration on Trade-related Intellectual Property Rights (TRIPS) and Public Health. The Court held that the TRIPS agreement must be: "interpreted and implemented so as to promote the rights of members to protect public health, especially the promotion and support of access to medicines". The Court also held that "lack of access to medicines due to high prices prejudices the human rights of patients to proper medical treatment". Tor Por 34/2544, full judgement available at http://www.cptech.org/ip/health/c/thailand/; see also www.msf.org.

[56] [1997] 3 S.C.R. 624, full judgement available at http://www.canlii.org/ca/cas/scc/1997/1997scc89.html.

[57] Communication No. 4/2004, UN Doc. CEDAW/C/36/D/4/2004 (2006), full judgement available at http://www.un.org/womenwatch/daw/cedaw/protocol/decisions-views/Decision%204-2004%20-%20English.pdf.

[58] 48 DLR (1996) HCD 438.

[59] Constitution of Bangladesh, 1972, article 32.

[60] Constitution of Bangladesh, article 18.

[61] CESCR, general comment No. 14, paras. 34-37. There is an overlap between, on the one hand, respect, protect and fulfil and, on the other hand, the requirement that health services etc., are available, accessible, acceptable and of good quality.

[62] CESCR, general comment No. 14, para. 34.

[63] 24 EHRR 423, full judgement available at www.echr.coe.int. On the duty to respect see also the case of *Andrea Szijjarto v. Hungary*, discussed in paragraph 75.

[64] *D. v. United Kingdom*, 24 EHRR 423, para. 53.

[65] In some more recent decisions, the Court has held that deporting people living with HIV/AIDS to countries where they may not be able to receive treatment may not amount to a violation of the European Convention if their illness has not reached an advanced stage, e.g. *Henao v. The Netherlands*, Application No. 13669/03, 24 June 2003.

[66] *Karen Noelia Llantoy Huamán v. Peru*, communication No. 1153/2003, UN Doc. CPR/C/85/D/1153/2003 (2005), full judgement available at http://www1.umn.edu/humanrts/undocs/1153-2003.html, see also www.crlp.org.

[67] The Committee found a violation of articles 2, 7, 17 and 24 of ICCPR.

[68] Resolution No. 10/85, case No. 7615 (1985), full judgement available at http://www.cidh.org/Indigenas/Annex1.htm.

[69] CESCR, general comment No. 14, para. 33.

[70] A.I.R. 1980 S.C. 1622.

[71] Communication No. 155/96 (2001) http://www1.umn.edu/humanrts/africa/comcases/155-96b.html. This case is on the borderline between "respect" and "protect". To the extent that the oil consortium was an arm of the State, it is a "respect" case. To the extent that the oil consortium was a private entity insufficiently regulated by the State, it is a "protect" case. Whether "respect" or "protect", the key point is that the Commission found that the State was responsible for breaches of health-related rights.

[72] CESCR, general comment No. 14, para. 33.

[73] Communication No. 241/2001 (2003), available at http://www1.umn.edu/humanrts/africa/comcases/241-2001.html; see also COHRE, "Housing and ESC Rights Law", 2004, p. 4.

[74] The database will be located at http://www.who.int/hhr/databases/en/ . It will also include information about relevant international human rights instruments and national Constitutions bearing upon the right to health. For an excellent summary of national jurisprudence on access to medicines see Hogerzeil, H. et al., "Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?", *Lancet*, 2006. COHRE and Interights also have excellent collections of the growing jurisprudence on economic, social and cultural rights, see www.cohre.org and www.interights.org.
