HUMAN RIGHTS COUNCIL

STATEMENT BY PAUL HUNT[1]

SPECIAL RAPPORTEUR ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH[2]

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President,
Distinguished Delegates,
Ladies and Gentlemen,

The health and human rights movement has made significant progress in recent years.[3] Members of the former Commission on Human Rights, and Human Rights Council, deserve credit for the contribution they have made to these positive developments. Resolutions adopted by the Commission and Council have drawn attention to vital right to health issues. Of course, many others have also made indispensable contributions, including specialised agencies and civil society.

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' and taking test cases, the movement is also developing new approaches and skills such as indicators, benchmarks, impact assessments and budgetary analysis.

If we are to progress further, however, it is very important that established human rights non-governmental organisations work on serious health and human rights issues, such as maternal mortality, just as vigorously as they campaign on disappearances, torture and prisoners of conscience.

It is also very important that more health professionals engage in the health and human rights movement. Health and human rights complement and reinforce each other. If we wish to operationalise the right to health it is imperative that many more health professionals grasp that human rights can help them deliver their professional objectives. We have to get across the message that human rights are assets and allies for health professionals.

Here there is a major, specific contribution that the Human Rights Council, and its Members, can make.

[1] On the occasion of the presentation of his reports A/HRC/4/28 (general report), A/HRC/4/28/Add.1 (summary of cases), A/HRC/4/28/Add.2 (Sweden), A/HRC/4/28/Add.3 (preliminary note).
[2] For convenience, I use 'the right to the highest attainable standard of health' or 'the right to health' as a shorthand for the full formulation of the right as set out in the relevant resolutions of the Commission on Human Rights and Human Rights Council.
[3] See chapter II, A/HRC/4/28.

The General Assembly resolution establishing the Human Rights Council mandated the Council to "promote the effective coordination and the mainstreaming of human rights within the United Nations system".[4]

My report signals some of the excellent work that WHO has done in relation to health and human rights. It also gratefully acknowledges the excellent support I have received from WHO, including its regional and country offices.[5]

However, I have to report that human rights are not mainstreamed within WHO where, in my experience, they remain marginal, contested and severely under-resourced.[6]

I urge the Council to do all it can to encourage the mainstreaming of human rights within WHO. Council members that are also members of WHO's Executive Board have a special responsibility to take steps. So I will be very interested to learn what Azerbaijan, Bahrain, Brazil, China, Japan, Mali, Mexico, Romania and Sri Lanka, as members of both the Council and WHO's Executive Board, plan to do to ensure that human rights are mainstreamed in WHO.

This is a good time for the Human Rights Council, and its Members, to take steps towards mainstreaming because of the appointment of WHO's new Director-General, Dr. Chan, and also because WHO's new programme of work includes the promotion of health-related human rights.

For my part, as I wrote to Dr. Chan on her appointment, I am at her disposal.

In short, it is of the first importance that the right to the highest attainable standard of health is not confined to the Human Rights Council: it must also be mainstreamed across WHO and other UN agencies.

Also, at the national level, the right to health must not be confined to Ministries of Foreign Affairs and Justice: it must be mainstreamed across Ministries of Health and other health-related ministries.

In 2005, the World Summit Outcome made both points very neatly: "We resolve to integrate the promotion and protection of human rights into national policies and to support the further mainstreaming of human rights throughout the United Nations system."[7]

Unfortunately, lack of time does not permit me to properly introduce another chapter in my report. Chapter III includes a sample of cases that signals how various tribunals have interpreted and applied health-related human rights (see from para 55).

In January last year, I undertook a mission to Sweden and the mission report is before the Council today.[8] I warmly congratulate the Government of Sweden for a standard

[4] Para 3, A/RES/60/251.
[5] See para 10, A/HRC/4/28.
[6] See para 50, A/HRC/4/28.
[7] Para 126, A/RES/60/1.
[8] A/HRC/4/28/Add.2.

of living, health status and quality of health care that are among the best in the world. However, my mission report identifies a number of areas where further progress can and should be made and I hope that I will have the opportunity to discuss these issues, and my recommendations, with the Government in Stockholm in due course.

In Sweden I learnt about the Government's excellent international policies on development, health and human rights. I was interested to learn more, however, about the degree to which these commendable policies are actually operationalised, on the ground, in developing countries.

So in February this year I visited Uganda to examine how the Swedish International Cooperation Agency (Sida) actually applies these Swedish international policies in the Ugandan health context.

Also, in October last year, I interviewed the Executive Directors of the Nordic-Baltic countries in the World Bank and IMF, with a view to understanding how Sweden's international policies on development, health and human rights are applied in the context of its membership of these financial institutions.

The Council has before it a preliminary note[9] on both visits (Uganda/2007, World Bank/IMF/2006).

This preliminary note also reports that in February 2007 I visited Uganda to follow up on my Ugandan mission of 2005.[10] As the Council will see from the note, I was greatly encouraged to find that the Government of Uganda has acted upon a number of the recommendations that I made in my earlier mission report.

Although much remains to be done, the Government of Uganda deserves great credit for making commendable progress, with the indispensable assistance of the UN country team, in particular the WHO country office.

I will report more fully to the Council on these matters as soon as possible. In the meantime, I wish to warmly thank the Governments of Sweden and Uganda for their exemplary openness and cooperation.

In one of my reports last year I examined maternal mortality as a human rights issue.[11] Each year over 500,000 women die in childbirth or from complications of pregnancy. As we sit here this afternoon, about 200 women will have died in childbirth. Crucially, most of these maternal deaths could have been avoided by a few well-known interventions.

I make no apology for once more highlighting maternal mortality in my present report to the Council.[12] Maternal mortality is a human rights catastrophe on a scale that dwarfs other human rights issues such as disappearances and the death penalty. The Commission on Human Rights devoted a great deal of time and energy to disappearances and the death penalty – and it was right to do so because these are

[9] A/HRC/4/28/Add.3.
[10] E/CN.4/2006/48/Add.2.
[11] A/61/338.
[12] From para 32, A/HRC/4/28.

human rights issues of enormous importance. But the Commission gave negligible attention to maternal mortality – despite the massive scale of the problem and despite the fact that maternal deaths raise vital issues concerning women's rights to life, health, equality and non-discrimination. Maternal mortality is a hugely important human rights issue for all States, whether they are low-income, middle-income or high-income.

I urge the Council to give maternal mortality the sustained attention it desperately needs.

I am delighted to report that the Government of India has invited me to look at maternal mortality within its jurisdiction. My mission will focus on just two states in India and will provide an excellent opportunity to identify the practical contribution that the right to health can make to the national and global struggle against maternal mortality. India's invitation confirms the great seriousness with which its Government is taking these issues. I am most grateful to the Government of India for the invitation.

I have recently been invited by the Minister of Foreign Affairs in Ecuador to urgently visit Ecuador to report on the aerial spraying of illicit crops on the Colombian side of the Ecuador/Colombia border. Ecuador alleges that this spraying is damaging the health of those indigenous people in Ecuador who live on or near the border.

This complaint is plainly within my mandate and I am presently considering whether or not to accept Ecuador's invitation. My difficulty is that any mission is a major undertaking and my schedule of projected missions this year is already complete and I am undecided whether it is realistic to add another.

If I go to Ecuador, my visit will not be confined to aerial spraying on the border. I will also consider some other serious right to health issues in Ecuador.

May I take this opportunity to warmly thank the Government of Ecuador for their invitation to investigate this serious allegation concerning the right to the highest attainable standard of health.

Steps have already been taken that will, I hope, permit me to undertake a country mission, later this year, on HIV/AIDS.

Very briefly, I would like to confirm that I continue to work on the preparation of draft guidelines for pharmaceutical companies on access to medicines. I expect to have a draft for consultation in the coming weeks.

I cannot close without expressing my profound concern about Iraq and the Occupied Palestinian Territory.

The murder and mayhem in Iraq is well known. But I wish to draw the Council's attention to an issue that, despite its acute gravity, receives far less attention. Over the last couple of years the issue has been seriously under-reported. I refer to the extremely troubling health situation of Iraqis who are internally displaced or refugees.

We do not know with certainty the numbers involved. According to some reports, there are about 2 million IDPs in Iraq and about 2 million Iraqi refugees, mostly in Syria and Jordan, but also Egypt, Iran, Lebanon and Turkey.

The health situation - access to water, sanitation, health care and medication - of many Iraqi IDPs is extremely precarious.

And this has to be seen in a health context that is frightening. According to one UN agency, the violence and instability in Iraq "is taking its toll on the health sector, possibly more than any other sector in Iraq."[13] I am advised that in some parts of Iraq doctors are attacked because they are doctors.

As for refugees, the generous hospitality of neighbouring host countries is becoming strained. The pressure on already fragile health services is acute. As the refugees' funds run out, many do not know how they will provide for their families' basic health needs.

In these circumstances, the Iraq humanitarian conference on displacement scheduled for 17-18 April in Geneva is extremely important. This is not specifically a pledging conference but an opportunity to understand the nature and scale of a huge humanitarian crisis.

I encourage all Governments to give this meeting - and these issues - their close attention and robust support.

President,

Starved of funds by Israel and the donor community, the health sector in the Occupied Palestinian Territory is in severe crisis. Many health workers - unpaid for many months – are on strike. In some cases, primary health services are failing, emergency rooms closing, and medicine for chronically ill patients is drying up.[14]

Only yesterday in Gaza the wall of a sewage effluent lake collapsed, spilling into the village of Um Nasser.

In June last year I publicly expressed my view that the donors' sanctions against the Palestinian Authority were inconsistent with their human rights responsibilities of international assistance and cooperation.[15] By cutting funds to the health sector without adequate notice, these were not economic sanctions - they were health sanctions. I know of no other case where donors have imposed health sanctions on the sick, infirm and elderly living under occupation. The Temporary International Mechanism was a belated, inadequate response.

I appreciate that, following the January 2006 elections, donors had a difficult political decision to make. It is precisely when difficult political decisions have to be made that

[13] *Iraq Displacement 2006 Year in Review*, IOM.
[14] *Further deterioration in access to medical services in the Occupied Palestinian Territory*, WHO press release, 23 March 2007.
[15] *UN health rights expert criticizes donors for failing to fulfil their humanitarian responsibilities in the Occupied Palestinian Territories*, OHCHR press release, 22 June 2006.

human rights are especially important. Human rights help to protect the weak and powerless in times of political crisis. Last year the donors failed to give proper weight to the human rights of sick, infirm and elderly Palestinians.

Whichever way the Palestinian political landscape evolves in the next few weeks, it is imperative that this grave human rights injustice is remedied as a matter of urgency.

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