Using All the Tools at Our Disposal

Poverty Reduction and the Right to the Highest Attainable Standard of Health

BY PAUL HUNT

FACED WITH A CAR THAT DOES NOT WORK, mechanics would be criticized for failing to use all the tools at their disposal to get it on the road. Why leave some tools unused on the workshop bench when they can help to get the job done?

For the most part, development practitioners fail to use the human rights tools at their disposal in the struggle against poverty. Of course, neither human rights nor anything else provide a magic solution to the immensely complex problem of global poverty. Nonetheless, human rights have a constructive contribution to make and a failure to use them is a missed opportunity of major proportions. There has been some progress at the policy level, much less progress at the operational level (see Piron and O'Neil 2005).

The human rights community has to shoulder some of the responsibility for the failure of development practitioners to consistently use human rights. Too often, the arguments in favor of human rights have been stronger on slogans than practical measures. But, in recent years, this has begun to change. The human rights community has made—and continues to make—concerted efforts to engage with national and international policy making in a practical, balanced and constructive manner. To do this it has been compelled to confront difficult issues, such as the impact of finite resources on policy choices, which has led to work on human rights tools, such as indicators, benchmarks, impact assessments and budget analysis (see Humanist Committee on Human Rights 2006; Fundar and Ford Foundation 2002; Hunt 2006). Although this remains work in progress, there is a growing maturity about the human rights movement that development practitioners should not ignore (see UN Committee on Economic 2001; UNDP 2000; OHCHR 2004; Yamin 2005).

The 'judicial' and 'policy' approaches

BROADLY SPEAKING, there are two ways of vindicating human rights, including economic, social, and cultural rights, such as the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," often shortened to the "right to the highest attainable standard of health" or the "right to health."

One way is via the courts, tribunals and other judicial and quasi-judicial processes (the 'judicial' approach). Another approach is by bringing human rights to bear upon policy-making processes so that policies and programs are put in place that promote and protect human rights (the 'policy' approach). Of course, the two approaches are intimately related and mutually reinforcing. Nonetheless, the distinction between them is important because the 'policy' approach opens up challenging interdisciplinary possibilities for the operationalization of human rights.

Lawyers have played an indispensable role in developing the norms and standards that today constitute international human rights law. Naturally, when it comes to the 'judicial' and 'policy' approaches, some lawyers are professionally drawn to the 'judicial' approach. Indeed in the context of the right to health, this approach has a vital role to play. As the UN High Commissioner for Human Rights, Louise Arbour, explains elsewhere in this volume, the courts have made a crucial contribution to the implementation of the right to health and it is very important that this contribution deepens and becomes more widespread.

In addition to the 'judicial' approach, however, it is also vital that the right to health is brought to bear upon all relevant local, national and international policy-making processes, including those for the reduction and elimination of poverty. It is this approach that is the focus of this article, drawing

upon some of my experiences in the UN human rights system (see also WHO, 2002 and WHO 2005).

Briefly, three elementary points about the 'policy' approach require emphasis. First, it depends upon techniques and tools that are not usually in a lawyer's brief case or repertoire. Second, it demands close cooperation amongst a range of disciplines and policy experts. Third, the 'policy' approach demands vigilant monitoring and accountability, but the accountability does not have to be judicial. It could, for example, take the form of publicly available rigorous human rights impact assessments that check whether or not the relevant policy has delivered positive human rights outcomes consistent with the state's national and international commitments.

The right to the highest attainable standard of health

AS UN SPECIAL RAPPORTEUR on the right to the highest attainable standard of health, my task is to help States, and others, better honor their right to health responsibilities arising from national and international human rights law (see Hunt's UN reports, statements and other interventions at www2.essex.ac.uk/human_rights_centre/rth).

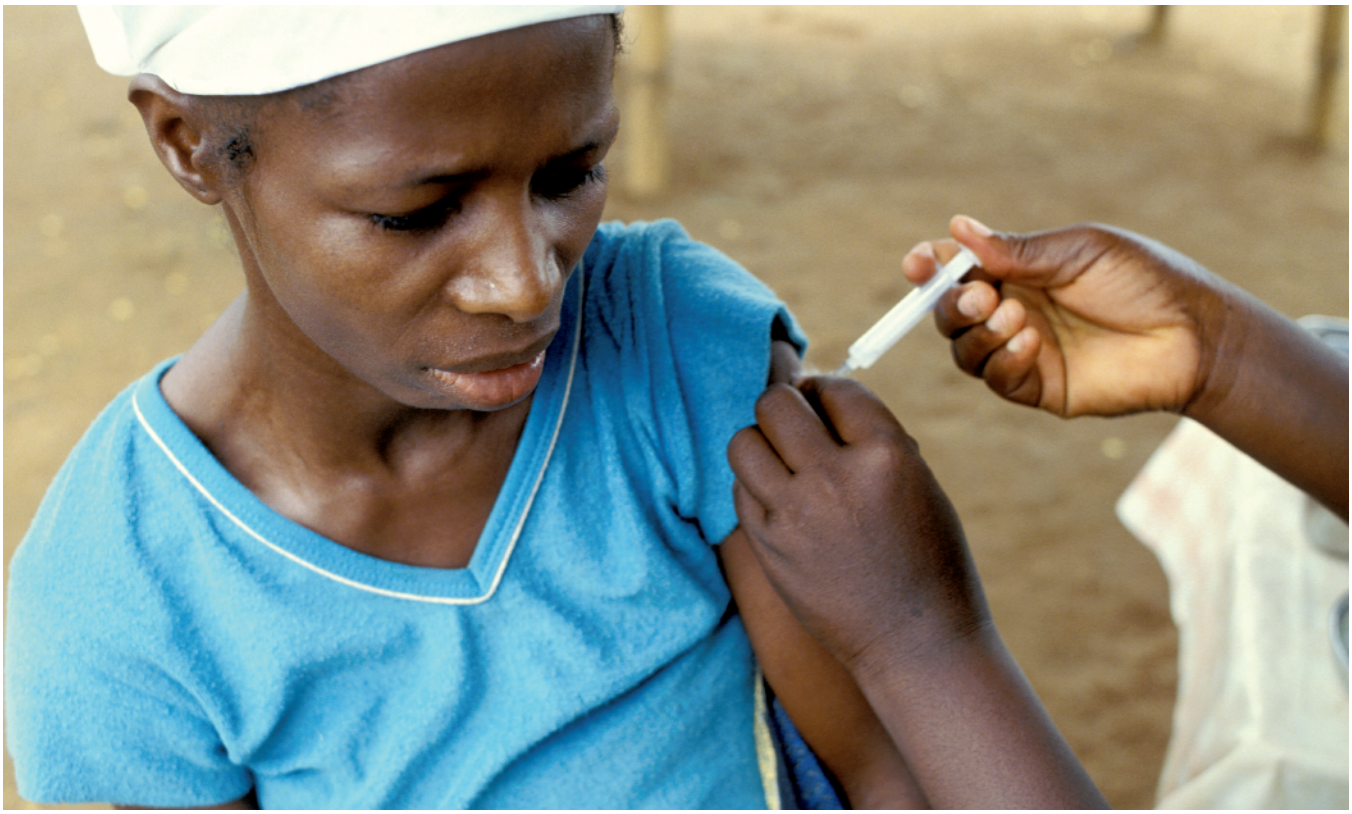
The right to health is enshrined in numerous national constitutions, as well as binding international human rights law. According to international law, the right to health encompasses both the right to health care and the underlying determinants of health, such as adequate sanitation and safe drinking water. Moreover, the right to health is closely related to the enjoyment of a number of other human rights and fundamental freedoms, including the rights to food, housing, education, participation and access to information. In my work, I have sought to apply the right to health, understood in this broad and interrelated manner, to the problem of poverty reduction.

Niger's Poverty Reduction Strategy

One of my reports to the UN Commission on Human Rights briefly considers Niger's Poverty Reduction Strategy (PRS) through the prism of the right to health (E/CN.4/2004/49, paras 57-75).

The report commends a number of the public health features of the PRS, such as the objective of ensuring that essential, high-quality medicines are available at affordable prices, a goal that reflects Niger's international right to health obligations.

Additionally, however, the report draws attention to some issues in the PRS that, had the right to health been taken into account when the PRS was prepared, would have been addressed somewhat differently. From a right to health perspective, for example, a pro-poor health policy should include education and information campaigns concerning the main health problems in local communities, including methods of prevention and control. Also, explicit attention should be given to the health situation of all marginal groups in the jurisdiction, including racial and ethnic minorities. Further, the right to health requires that transparent, accessible and effective monitoring and accountability mechanisms be established, providing rights-holders (e.g. individuals) with an opportunity to understand how duty-bearers (e.g. ministers and officials) have



discharged their obligations in relation to the PRS.

Although a commendable poverty reduction strategy, from the right to health perspective, Niger's PRS did not give sufficient attention to these (and some other) issues.

Uganda's neglected diseases

In 2004, I was invited by the Government of Uganda to visit and prepare a report on neglected diseases and the right to health (E/CN.4/2006/48/Add.2). Also known as tropical or poverty-related diseases, they are mainly suffered by poor people in poor countries. In Uganda these diseases include river blindness, sleeping sickness and lymphatic filariasis. These appalling diseases attract little health research and development because those afflicted invariably have negligible purchasing power. The market fails them.

Examining Uganda's neglected diseases through the lens of the right to health underlines the importance of a number of policy responses. First, it underscores the imperative of developing an *integrated* health system responsive to local priorities. Vertical interventions that focus on one particular disease can actually weaken the broader health system. While there might be a place for some vertical interventions, they must be designed to strengthen, not undermine, an integrated health system. Second, village health teams are urgently needed to identify local health priorities. Their local knowledge about the prevalence of disease in the community will enhance the perspectives provided by a health official from the regional or national capital. Third, of course more health professionals are essential, but also incentives are needed to ensure that the health workers are willing to serve these remote neglected communities. Fourth, there are myths and misconceptions about the causes of neglected diseases: these can be dispelled by accessible public information campaigns. Fifth, some of those suffering from neglected diseases are stigmatized and discriminated against: this, too, can be tackled by evidence-based information and education. Sixth, the international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance. Seventh, effective monitoring and accountability devices must be established. Existing parliamentary and judicial accountability mechanisms are not enough in relation to those diseases mainly affecting the most disadvantaged. In my Ugandan report I suggest a way of enhancing accountability in relation to neglected diseases.

Neglected diseases mainly afflict neglected communities. It was the right to health analysis—and its preoccupation with disadvantage—that led, in the first place, to the identification of this neglected issue as a serious right to health problem demanding much greater attention.

Conclusion

A RIGHT TO HEALTH APPROACH to poverty reduction does not imply a radically new departure. Rather, it is likely to reinforce and enhance elements already existing in many anti-poverty strategies. The Government of Uganda, for example, already has a number of policies and programs that will help to tackle neglected diseases. Nonetheless, an examination of the problem through the right to health lens can provide insights, and signal measures, that sharpen and deepen existing initiatives (see also Hunt's reports on Peru, E/CN.4/2005/51/Add.2; Mozambique, E/CN.4/2005/51/Add.3; and Romania, E/CN.4/2005/51/Add.4).

Confronted with such a complex and colossal challenge as global poverty, it is extremely important that development practitioners use all the tools available in their workshop, including the national and international human rights commitments of developing and developed states.

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