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STATEMENT BY PAUL HUNT

**SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE
ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF
PHYSICAL AND MENTAL HEALTH**

TUESDAY 29th MARCH 2005

Mr. Chairman, Distinguished Delegates, Ladies and Gentlemen,

The right to the highest attainable standard of physical and mental health encompasses health care – for instance, access to a doctor or nurse – and also the underlying determinants of health – for instance, access to safe drinking water and adequate sanitation. In short, the right is both complex and extensive. I suggest it is among the most extensive human rights in the international lexicon.

Mr. Chairman, with your permission I will sometimes refer to the right to the highest attainable standard of physical and mental health as ‘the right to health’, by way of a convenient shorthand.

In my work, I adopt two basic approaches with a view to making this complex human right easier to understand.

First, I identify particular elements of the right, and focus on them. For instance, last year I looked at sexual and reproductive health rights. This year my report examines the right to health of people with mental disabilities. Future elements might include maternal health, access to essential medicines, environmental health, and so on.

In this way, over time, it will be possible to build up a reasonably complete picture of the right to health, including the relevance of the right to particular groups.

The second approach I adopt, with a view to making the right easier to grasp, is to develop a common way of approaching the right to health. This common approach looks at the right to health in terms of freedoms, entitlements, non-discrimination and equality, participation, international assistance and cooperation, monitoring and accountability, and so forth. This provides a common analytical framework that can then be applied to selected elements of the right to health.

I hope that, over time, this analytical framework will be improved and refined, and that it gradually becomes a widely accepted way of unpacking and understanding this complex human right.

Mental disability and the right to health

In my annual report this year, I apply this common analytical framework to the right to health of persons with mental disabilities because their health care and support needs are among the most neglected in the world.

Mental and behavioural disorders account for about 12% of the global burden of disease. Yet the mental health budget of most countries is less than 1% of their total health expenditure.

More than 40% of countries have no mental health policy. Over 90% of countries have no mental health policy that includes children and adolescents.

The closer you look, the worse the picture becomes.

If mental health care and support services *are* available, users are especially vulnerable to violations of their human rights within those settings. This is especially true in segregated service systems, such as psychiatric hospitals, orphanages, prisons, and institutions for people with intellectual disabilities.

I have received numerous accounts of the long-term, inappropriate institutionalization of persons with mental disabilities in psychiatric hospitals, and other institutions, where they have been subjected to human rights abuses, including: rape and other sexual abuse by other users and staff; forced sterilizations; being chained to soiled beds for long periods; and the administration of treatment without informed consent.

In one European country last year, more than 15 patients died, at a psychiatric hospital, from malnutrition and hypothermia.

In many cases, persons with severe mental disabilities are misdirected towards prison rather than appropriate mental health care or support services.

Other groups face particular vulnerabilities. Women with mental disabilities are especially vulnerable to sexual violence. Ethnic and racial minorities often face discrimination in access to – and treatment in – mental health care and support services. Despite acute mental health care needs, indigenous peoples are often ignored.

The stigmatization of various mental conditions often leads to discrimination. Those affected are often denied equal opportunities to a wide range of human rights and fundamental freedoms.

WHO recommends that mental health services, including support services, be based in the community and integrated as far as possible into general health services. Yet in many countries, mental health care is not provided according to this model but is predominantly centralized in large psychiatric hospitals – with little or no care and support services available in the community.

In many countries, including developed countries, a lack of accessible community-based services and social housing leaves persons with mental disabilities sleeping rough on the streets.

Despite all this, there is some hope. Once relegated to living in closed institutions, many people with mental disabilities have shown that they can live full and meaningful lives in the community. People once thought incapable of making decisions for themselves have shattered stereotypes by showing that they are capable

of living independently – provided they have appropriate legal protections and support.

There is another ground for hope. Even with very limited resources, there is a great deal that countries can do. Even a country with few resources can – for example - include the recognition, care and treatment of mental disabilities in training curricula of all health personnel; promote public campaigns against stigma and discrimination of persons with mental disabilities; support the formation of civil society groups that are representative of mental health care users and their families; formulate modern policies and programmes on mental health; and establish an independent system of monitoring and accountability for those with mental disabilities.

At the end of my report I devote short sections to the particular vulnerabilities and needs of those with intellectual disabilities, such as people with Down's syndrome; the right to community integration; and the issue of informed consent – an issue that needs urgent reconsideration.

Country mission reports

Mr. Chairman – I have three country mission reports before the Commission today, on Mozambique, Peru and Romania.

The reports speak for themselves and here I will confine myself to just a few remarks on each.

I would like to take this opportunity to very warmly thank the Governments of Mozambique, Peru and Romania for extending invitations to me and for providing their full cooperation throughout my visits.

While each country is very different, there are some common themes in the three reports.

Perhaps the most striking is that each country has – to its credit - recently developed a number of excellent policies for their health sectors.

Yet, in some cases, there is a gap between these impressive policies and actual implementation on the ground.

The right to the highest attainable standard of health requires some sort of accessible and transparent monitoring and accountability arrangements. While the details vary, in each country there is room for improvement in relation to monitoring and accountability for the right to health.

An effective monitoring and accountability arrangement can help a country narrow the gap between policies and practice.

Another way of narrowing the gap between policies and practice is by active and informed community participation in the health sector. In parts of Peru, there is dynamic community participation in health issues. In Mozambique and Romania, community participation in the health sector is less well-developed.

I note in passing that corruption cannot survive where there is effective monitoring, accountability and community participation in the health sector. By definition, a policy based on the right to health is also an anti-corruption policy.

Mozambique

With the assistance of the international community, Mozambique has taken impressive strides in recent years. But the reality is that it remains desperately short of resources. Without more health resources – and more health professionals enjoying improved terms and conditions of work – it will be impossible for Mozambique either to achieve the health-related Millennium Development Goals, or to make satisfactory progress towards the realization of the right to health. This places a heavy responsibility on both the Government of Mozambique and the international community.

Peru

Peru has a range of policies that aim to address the health problems of the poor and other vulnerable groups. Yet there is currently no comprehensive pro-poor or equity-based health policy. Thus, my main recommendation in relation to Peru is that the Government, in cooperation with all stakeholders including the international community, formulate a comprehensive health policy and strategy, underpinned by the right to health, that is specifically designed to address inequity, inequality, discrimination and the situation of those living in poverty.

Presently, Peru's debt repayments absorb about 24% of the national budget. So I also recommend that a significant proportion of this debt be cancelled – on condition that the released funds are re-allocated for the implementation of the pro-poor equity-based health policy already mentioned.

Romania

As a state in transition, Romania is in a very different situation. Nonetheless, it has a number of pressing right to health issues, not least the health situation of the Roma.

Here, however, I draw attention to a key recommendation concerning mental health. Tragic events in recent years confirm that Romania should give serious and urgent attention to the appointment of an independent mental health commissioner. The commissioner should be mandated to investigate allegations of human rights violations, including in relation to mental health-care facilities. He or she should provide independent advice to the Ministry of Health and hospital directors, thereby helping them to respect the right to health and other human rights of all those with mental disabilities.

Uganda

Mr. Chairman, over the weekend I returned from a mission to Uganda. I will prepare a mission report for next year's Commission on Human Rights. Today, without going into substance, I would like to make a few remarks about this mission.

In its resolution of 2003, the Commission asked me to analyse the issue of neglected diseases - that is, those diseases mostly suffered by the poorest people in the poorest countries. I was very pleased to receive an invitation from the Government of Uganda to undertake a country mission specifically on neglected diseases in Uganda.

The mission enabled me to deepen my understanding of neglected diseases by way of a country case study. Crucially, an expert on neglected diseases, from WHO in Geneva, accompanied me throughout the Ugandan mission, providing me with indispensable technical advice.

Mr. Chairman, I wanted to bring these matters to your attention because the Ugandan mission is a good example of fruitful cooperation between a Government, a UN Specialised Agency, and a Special Rapporteur, in response to a request from this Commission. In my view, this is precisely how the UN system should work.

I am very grateful to the Government of Uganda, and WHO, for providing me with an opportunity to fulfil my mandate, on neglected diseases, as set out in the Commission resolution of 2003.

Conclusion

In conclusion, Mr. Chairman, I thank the secretariat of the OHCHR for their highly professional support over the last twelve months, without which I would not have been able to undertake my duties.
