

**10<sup>th</sup> CANADIAN CONFERENCE ON INTERNATIONAL HEALTH**

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**PANEL DISCUSSION ON THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH**

**by Paul Hunt, UN Special Rapporteur on the right to health**

My presentation this morning tried to give an overview of some of the opportunities and challenges provided by the human right to health.

This afternoon, I would like to revisit some of this terrain, and go over some of it in a little more detail, in the particular context of sexual and reproductive health.

Of course, my remarks are introductory and incomplete. A number of the issues that I mention will be developed by my colleagues on the panel and, I hope, by participants in the discussion afterwards.

In fact, I expect to be one of the main beneficiaries of our discussions this afternoon – what I mean is that as Special Rapporteur on the right to health I have to submit a report to the UN General Assembly and also one to the UN Commission on Human Rights. Next month, I submit my next report to the Commission and I have decided that a significant section of this report - perhaps some three or four pages - will be on the rights to sexual and reproductive health.

There are a number of reasons why I have chosen this issue to highlight in my next report. One is that next year is the tenth anniversary of Cairo and I would like to make a modest contribution to Cairo+10. Another is that, as we all know, there is an attempt in some quarters to reverse the hard-fought progress made in Cairo and Beijing - and, in my opinion, it is extremely important that this progress, and the rights to sexual and reproductive health, are not compromised or undermined in any way. I hope that my forthcoming report will serve as a straightforward and uncomplicated reminder that the rights to sexual and reproductive health are an integral element of the internationally protected human right to health.

So, for me, this panel serves as a very valuable opportunity to listen and learn from others before the preparation of my next Commission report.

First, a few remarks about where the right to health comes from.

Although neglected for many years, the human right to health is a firmly established part of international human rights law. It is enshrined in the WHO Constitution, reflected in UDHR, and elaborated in various international human rights treaties, including ICESCR, CEDAW, CERD and CRC.

The right to health is also guaranteed in several regional human rights treaties, such as the African Charter on Human and Peoples' Rights, the Protocol of San Salvador in the Inter-American human rights system, and the European Social Charter.

This morning I remarked upon the court-based approach, and the policy-based approach, to the right to health, and I emphasised that both approaches are important. Here I observe that a number of significant right to health cases have been decided by the regional human rights

bodies, such as the Ogoniland litigation concerning the activities of oil companies in the Niger Delta.

Also this morning I remarked that the right to health, or the right to health care, is enshrined in some 60 constitutions. Moreover, an additional 40 constitutional provisions include health-related rights, such as the right to reproductive health care. Further, a large number of constitutions set out state duties in relation to health, from which it may be possible to infer health entitlements.

In some jurisdictions, these constitutional provisions on the right to health have generated significant jurisprudence, such as the recent decision of the Constitutional Court of South Africa in the Treatment Action Campaign case, concerning the right of pregnant women and their newborn children to have access to anti-retrovirals to combat mother-to-child transmission of HIV.

If that is where the right to health comes from, what does it mean?

The right to health includes the right to health care - but it goes beyond health care to encompass adequate sanitation, healthy conditions at work, and access to health-related information, including on sexual and reproductive health. It includes freedoms, such as the right to be free from forced sterilisation and discrimination, as well as entitlements, such as the right to a system of health protection. The right to health has numerous elements, sort of sub-rights, including maternal, child and reproductive health. Like other human rights, the right to health has a particular preoccupation with the disadvantaged, vulnerable, and those living in poverty. Although subject to progressive realisation, the right imposes some obligations of immediate effect, such as the obligations of equal treatment and non-discrimination. It demands indicators and benchmarks to monitor the progressive realisation of the right. As I sought to argue this morning, developed states have some responsibilities towards the realisation of the right to health in poor countries - we learn this from the Millennium Declaration, including MDG 8, as well as the provisions of international human rights law on international assistance and cooperation.

Sexual and reproductive health means that women and men have the freedom to decide if and when to reproduce. This includes the right to be informed about, and to have access to, safe, effective, affordable, acceptable and comprehensive methods of family planning of their choice, as well as the right of access to appropriate health care services that will, for example, enable women to go safely through pregnancy and childbirth. (CESCR General Comment 14, para 14, footnote 12.) The realisation of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy, and includes appropriate sexual and reproductive health services. (CESCR General Comment 14, para 23.)

Katherine will be exploring in more detail how the UN human rights treaty-bodies have approached the rights to sexual and reproductive health, and also how these rights have been treated in the world conferences, such as Cairo and Beijing.

So, as we have agreed, I will leave these crucial parts of the picture to her and make only two brief remarks. First, it is a source of regret that the MDGs do not refer to sexual and reproductive health. This omission is especially striking because Cairo, Beijing, and the International Development Targets (the forerunners of the MDGs), include reproductive health. Second, I am very pleased that the right to health resolution passed by the UN Commission on Human Rights this year explicitly includes sexual and reproductive health. Given the current political climate, this was a remarkable achievement - and it would not

have happened without the lobbying skills of the organisers of this panel and without the support of the Governments of Switzerland and Canada.

Where does the mandate of the Special Rapporteur fit into all this?

First, as mentioned this morning, one of my objectives is simply to promote the notion that the right to health is a fundamental human right. Thus, I aim to promote the rights to sexual and reproductive health as fundamental human rights. Another objective is to clarify and explore the contours and contents of the right to health - including the rights to sexual and reproductive health. There is a lot of national, regional and international human rights jurisprudence on the rights to sexual and reproductive health and, if I have the capacity, I would like to pull this material together as a resource for policy makers and activists. A third objective is to find ways of operationalising the right to health - and the rights to sexual and reproductive health. Again, a collection of good practices for the delivery of the rights to sexual and reproductive health could be a useful resource for policy makers and activists alike.

This morning I also mentioned the twin themes of poverty and discrimination. The relationship between poverty and sexual and reproductive health is well known. Empowering women and men to make decisions about whether to have children, when and how often to do so, is essential to poverty eradication. Reproductive illness and death help to perpetuate a vicious cycle of poverty among the poor. Poor and uneducated women are far more likely than other women to die or be disabled during pregnancy. On the macro-economic level, rapid population growth has a negative impact on the pace of economic growth in developing countries.

As for discrimination, sexual and reproductive health services are central to women's empowerment and improvement in the quality of their lives. With fewer children, more time between births, and better reproductive health, women find it easier to work outside the home, raise their incomes and provide for their families. They also have more time to participate in the social and political life of their communities.

In this context, I would like to draw attention to the discrimination and stigmatisation suffered by sexual minorities. While discrimination and stigma are multifaceted, at the most basic level, same-sex relations are still criminalised in some 70 countries. Homophobia and related discrimination has a tangible impact on mental health, and this is particularly the case in relation to young people who are, or are perceived to be, gay, lesbian or transgender. In some countries, lesbians, gay men and transgender or bisexual people are tortured at the hands of the State on account of their sexual identity - this has been widely documented by human rights organisations, including Amnesty International. The relationship between torture and violence on the one hand and the right to health on the other is clear.

My co-panellists will elaborate on some of the issues I have only touched upon. But I would like to close with an indication of the manner in which I hope to address, very briefly, the rights to sexual and reproductive health in my work.

First, as I explained at the beginning, I expect to include a section on the rights to sexual and reproductive health in my forthcoming report to the UN Commission on Human Rights. I do not anticipate that this section will break any new intellectual ground, but it will confirm and clarify that the rights to sexual and reproductive health are integral components of the right to health.

Second, as Special Rapporteur I am expected to go on a couple of country missions each year and to report thereafter to the Commission on Human Rights. In December, for example, I go on mission to Mozambique. In these missions and reports, I plan to give due regard to the rights to sexual and reproductive health.

Third, so far as my resources permit, I am very keen to interrogate the health-related MDGs from the perspective of the right to health - and if I do, this exercise will certainly encompass the rights to sexual and reproductive health.

Similarly, so far as my resources permit, I am very keen to examine poverty reduction strategy papers, including PRSPs, through the prism of the right to health - and this, too, will enable me to address the rights to sexual and reproductive health.

Finally, I am attempting to gather right to health good practices and, of course, I am hoping to include some on sexual and reproductive health.

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