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Public Health and Human Rights: at the Crossroads

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What are the messages we can take from this important conference? What are the lessons we can learn from the presentations this morning?

One key lesson is that public health and human rights have reached a major crossroads.

Another is that the relationship between public health and human rights is so close that it would be absurd if we fail to do all we can to make it prosper.

It is as clear as crystal that the right to the highest attainable standard of health - or 'the right to health' - depends upon the interventions and insights of public health. Obviously, the right cannot be realised without public health programmes.

Equally, we now understand that classic, long-established public health objectives can benefit from the newer, dynamic discipline of human rights.

Since my appointment in 2002, I have produced about twenty UN reports on the right to the highest attainable standard of health.¹ Some of these reports are on general themes, most recently on maternal mortality.² Some of them are on the right to health in specific countries.³

Time and again, these reports illustrate the common ground between public health and human rights. They show how human rights can help to reinforce *existing*, good, health programmes. They also show how human rights can sometimes help to identify *new*, equitable, health policies.

¹ These various reports, as well as other presentations, press releases, interviews etc are available at the website of the Right to Health Unit, Human Rights Centre, Essex University, England:
http://www2.essex.ac.uk/human_rights_centre/rth/

² In addition to maternal mortality, other thematic reports consider e.g. health professionals and human rights education; the skills drain of health professionals; access to medicines; sexual and reproductive health rights; mental disability; HIV/AIDS; indigenous peoples; poverty and the right to health; the health-related Millennium Development Goals; and a human rights-based approach to health indicators. All these reports are available on the website in footnote 1.

³ There are country specific reports on: Mozambique, Peru, Uganda and Romania. Additionally, there is a joint report on Guantanamo Bay and another on Lebanon/Israel (regarding the conflict of July/August 2006). There is also a report on the World Trade Organisation. A report on Sweden will be available shortly. All these reports are available on the website in footnote 1.

For example, on visiting Sweden I found a health system that is among the best in the world.⁴ But I also learnt that, while two Swedish cities have introduced harm reduction programmes for intravenous drug users, these programmes are unavailable elsewhere in the country. This unjustified, uneven access to life-saving programmes is inconsistent with the right to health.

Asylum seekers are among the most vulnerable people in Sweden – as they are in all countries. They are precisely the type of disadvantaged group that international human rights are designed to protect. But in Sweden I found that asylum seekers are not provided with the same medical services as others. In my view, such discriminatory practices are also inconsistent with Sweden's right to health obligations.

My visit to Romania confirmed that the Roma ethnic minority faces particular obstacles to its enjoyment of the right to health. The root causes of these obstacles are poverty, stigma and discrimination. Human rights - including equality, non-discrimination and participation - can strengthen policies that tackle these entrenched obstacles. The Roma community health mediator scheme, for example, can and should be extended.

I also learnt that although Romania has ratified all the major human rights treaties, and although these bear closely upon the duties of health professionals, Romanian health professionals receive no education or training in human rights. In these circumstances, how can they possibly honour their ethical and legal human rights responsibilities?

On visiting Peru I found acute health disparities between the indigenous and dominant populations. Mining has led to the contamination of indigenous peoples' land and water. Peru's health professions make few attempts to enrol indigenous students. Health professionals' education shows little awareness of indigenous culture.

From the right to health perspective, one of the first steps towards tackling these problems is to establish genuine participatory processes, on health issues, for indigenous peoples. Peruvian civil society is actively working on enhancing such participation. To its great credit, CARE-Peru is playing a leading role in this dynamic process.

In Uganda, I met a girl who was suffering from disfiguring lymphatic filariasis. Mocked, bullied and unsupported, she had given up school – a victim of multiple human rights violations. The right to health signals the policies that should address this desperate unfairness, including public information campaigns that dispel myths about lymphatic filariasis, as well as other neglected diseases – public information campaigns that promote non-discriminatory behaviour towards those afflicted.

I could give many other examples from my reports, but these are enough to reaffirm the common ground shared between public health and human rights. Both public health and human rights stress the importance of the underlying determinants of

⁴ At the end of the country mission to Sweden, I made some preliminary remarks to the press upon which the following observations are based. The preliminary remarks to the press can be found at the website in footnote 1 under the heading 'press releases, press statements and media interviews'.

health, as well as health care. Both look beyond the health sector. Both struggle against discrimination and disadvantage. Both demand cultural respect. Both attach great importance to public information and education. And so on.

Human rights strengthen public health in several ways, not least by introducing a set of rules - guidance for policy-making, as well as by demanding accountability.

Human rights ask awkward questions.

As you devise this new health programme, how will you ensure that the voices of women and girls are heard and respected? How are you ensuring that the poor and vulnerable have access to these health services? How are you measuring the impact of that new mine on the health of neighbouring communities? How are you measuring whether or not access to health care is being progressively improved? If you are using indicators and benchmarks, are they disaggregated on the grounds of sex, ethnicity and other prohibited grounds of discrimination? Why are maternal and infant mortality rates static - or worsening - for some ethnic minorities? Are your health programmes respectful of minority cultures? Are they available in common minority languages?

But human rights not only ask awkward questions, they also require answers – that is what accountability is all about.

For example, if health outcomes are not improving, we need to know why, so those responsible can adjust the relevant policies and programmes.

If the evidence shows that a new industrial plant is damaging health, we need to identify what is going to be done and by whom. Who is responsible for what? What is the mining company going to do? What is the local authority going to do? What is the State going to do?

If those living in poverty do not have access to essential health care, water and sanitation, we need to identify the obstacles so those responsible can take specific, targeted remedial action – and if they fail to take all reasonable steps, the poor need to be told why.

In short, human rights accountability asks questions and requires answers, *not* with a view to blame and punishment, but with a view to identifying what works, what does not, and who is responsible.

Accountability is a powerful human rights tool for improving the health of all.

As a guest in your country, and not having been invited by your Government, far be it for me to insist that any of this has any direct relevance to the USA!

Nonetheless, if I were on official UN mission to the USA, I would be interested to know, how do more than 40 million uninsured - and underinsured - Americans secure access to health care? Why is infant mortality the highest among OECD countries? Why is infant mortality for African American children twice that for white children? How is it that in South Dakota a white woman is almost twice as likely to receive

adequate prenatal care than a Native American woman? Why is it that the maternal mortality rate for African American women is more than four times the rate for white women, and three times the rate for Hispanic women? In American prisons, how many men and women suffer from mental disorders? How is it that obesity rates for adults almost doubled between 1980 and 1999? What percentage of people living with HIV/AIDS receives appropriate care and medication? May I see the national, comprehensive, strategic plan for HIV/AIDS? And how much human rights education and training is provided to public health professionals?

The answers to these - and many more - questions bear upon the human rights responsibilities of the US Government.

In my reports I have found that if the right to the highest attainable standard of health is brought to bear upon national health policies and programmes, they are more likely to be equitable, inclusive, participatory, robust and sustainable. This has applied in Sweden, Peru, Uganda and the other countries that I have officially visited. I leave you to judge whether the same might be said for the USA.

When I opened my remarks this morning, I suggested that one of the key lessons emerging from our conference is that public health and human rights have reached a major crossroads.

Clearly, the right to health has an important role to play in the deepening relationship between public health and human rights. And yet, bizarrely, until very recently, we did not really know what it meant. Until literally the last six years or so, the right to health was little more than a slogan – a sort of bumper sticker.

But now, thanks to the work of innumerable organisations and individuals, in both North and South, the content of the right to health is becoming clearer. Collectively, we are learning how the right can be operationalised. Together, we are developing tools like indicators, benchmarks and impact assessments that enable the right to health to take its proper place in policy-making processes. In a remarkably short time, the right to health has come a very long way.

Of course, we have not figured out all the implications of the right to health – and we probably never will. The only human right or discipline without dilemmas and disputes is one that has atrophied and died.

In my view, *for the first time*, the key pieces are now in place for public health and human rights, including the right to health, to invigorate and enrich each other in an operational, systematic and sustained way.

But I have to also say frankly that there is no chance of us moving forward in the right direction - there is no chance of systematically operating the right to health – without the active engagement of many more health professionals in this enterprise. That is why I attach such importance to this conference.

To be blunt, in my UN work I am often dismayed by the lack of knowledge about human rights among health professionals. Of course, there are honourable exceptions, but most health professionals in most Ministries of Health have not even heard of the

right to the highest attainable standard of health. If they have heard of it, they have no idea what it means, neither conceptually nor operationally. If they have heard of it, they are probably worried that it is something that will get them into trouble. I am not reproaching them – it is not their fault if they have never been told about the contribution that human rights can make to their work. The problem is partly one of language: public health and human rights have much in common, but the language used is often different.

We have gone about as far as we can with public health and human rights unless we can generate much more support from many more health professionals. That is what I had in mind when I said, at the beginning of these remarks, that we have reached a major crossroads.

It is imperative 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.

If we are to make progress, we have to get across the message much more clearly and widely that human rights, including the right to health, are allies and assets for health professionals to use – to devise better policies and programmes; 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.

Last year, a group of world leaders issued an important Call to Action on the right to health. Jimmy Carter, Bill Clinton and other luminaries from around the world signed up.⁵ Of course, ideological resistance to the right to health remains at the highest levels of some Governments. But this is not where our main obstacle lies.

The more pressing challenge is to convince the membership of health professionals' associations about the new maturity - and rich potential - of the right to health and other human rights. Only then will be able to go forward with confidence.

That is why this conference is so important and timely. With the support of your members we can make it over the crossroads and stride off confidently in the right direction. The future of public health and human rights depends upon this indispensable support.

⁵ This Call to Action (dated 9 December 2005) is available on the website in footnote 1 under the heading 'press releases, press statements and media interviews'.