

10th International Women and Health Meeting

Health Rights, Women's Lives: Challenges and Strategies for Movement Building

21-25 September 2005

New Delhi, India

Valedictory Address

by Paul Hunt

*UN Special Rapporteur on the right to the highest attainable standard
of health ('the right to health')*

One of the messages I want to convey at the end of this extraordinary conference is that the right to health is coming of age – it is maturing – and reaching a crucial new stage in its evolution.

Increasingly, the right to health is recognised to be a fundamental human right, no less than freedom of expression and the right to a fair trial.

Thanks to the work of innumerable activists, academics and others, the scope of the right to health – its legal content – is becoming clearer.

We are developing new ways of analysing – of unpacking – the right to health, making it easier to grasp and understand.

We are learning how to operationalise the right to health – how to make it real – and here we draw from pioneering work, for example, on HIV/AIDS and human rights.

Gradually we are developing new tools to measure the right to health, in particular by way of indicators and benchmarks.

More and more NGOs – and national human rights institutions – are campaigning on the right to health.

And increasingly health professionals are recognising the rich potential of the right to health as a way of deepening, reinforcing and enhancing their work.

But what is it that the right to health brings to policy making?

In general, abstract terms it brings a set of fundamental principles, such as dignity, well-being, autonomy, and equality.

It places the interests of individuals and communities – their dignity and well-being – at the heart of policy making.

It brings a keen preoccupation with the vulnerable and disadvantaged, including those living in poverty.

The right to health emphasises primary health and it demands effective health systems that are responsive to local priorities.

It places obligations – moral and legal – on states and requires that they be held to account for their conduct.

It insists that rich states have a responsibility to help developing states realise the right to health – in this way responding to the shocking inequality in global health that shames our contemporary world.

One of my responsibilities as UN Special Rapporteur on the right to health is to clarify what, in more *practical* terms, the right to health brings to a particular health problem.

Earlier this year I was invited by the Government of Uganda to visit and prepare a report on neglected diseases. By neglected diseases I mean those that are mainly suffered by poor people in poor countries. In Uganda these diseases include river blindness, sleeping sickness and lymphatic filariasis. These terrible 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 underlined the importance of a number of policy responses. It underscored 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 - an integrated system is needed. Village health teams are urgently needed to identify the local health priorities. They know which neglected diseases their village is afflicted with much better than a health official in the regional or national capital. 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. There are myths and misconceptions about the causes of neglected diseases – these can be dispelled by accessible public information campaigns. Some of those suffering from neglected diseases are stigmatised and discriminated against – this too can be tackled by evidence-based information and education. The international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance. 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 and in my Ugandan report I will be suggesting a way to enhance accountability.

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.

My point is that the right to health has something precise, practical and constructive to contribute to serious, complex health issues, such as neglected diseases. Of course, it

does not bring a magic solution. Also, you could identify these policy responses for neglected diseases without reference to the right to health. But the right to health can help to identify these responses and, where they already exist, the right can reinforce them.

Because of its evolution in recent years, the right to health – as never before - is in a position to shape national and international policy making. The traditional human rights techniques – ‘naming and shaming’, letter writing campaigns, taking test cases, and so on – are still needed. But, in addition, there are new possibilities for the right to health to influence and animate policy-making processes.

In my view, we are at the threshold of a new era for the right to health. Whether we manage to take those crucial steps across the threshold remains to be seen. But the threshold lies right in front of us.

As many presentations at this conference have shown, the right to health provides a powerful tool for highlighting the gender dimension in health issues. Neglected diseases have a gender dimension. In Uganda women are primarily responsible for washing clothes and several neglected diseases arise from water, which means that women are especially exposed to these diseases. My report on the World Trade Organisation and the right to health signals – as have many other commentators - the gender dimension of trade liberalisation. For example, if water services are privatised this is likely to have an impact, for good or ill, on women and girls living in communities where they have primary responsibility for fetching water. My report on mental disability and the right to health brings out that women with mental disabilities are especially vulnerable to forced sterilisations, rape and other forms of sexual violence, a theme that has recurred throughout this conference. And of course my report on sexual and reproductive health rights - with its call for States to take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination - has a strong gender dimension, and this theme has also recurred during our meeting.

In short, as many in this conference room know much better than I, the right to health has the potential to expose and tackle gender discrimination.

Of course, those of us committed to the right to health find obstacles in our path. Sometimes we are derided on personal and ideological grounds, which is a sure sign that we are winning the substantive arguments.

Sometimes it is not *we* who are derided, but the right to health. Our opponents say that the right to health is too vague – too imprecise – to be taken seriously.

It is time to confront and reject this argument.

The right to health is no less precise than reasonableness, fairness, justice, democracy and freedom – all concepts that routinely shape policy and even come before the courts for adjudication.

In reality, how precise are the well-established civil and political rights? How precise are freedom of expression, the prohibition against torture, and the right to privacy? One tribunal says torture means one thing, and another overturns that interpretation and asserts another. If civil and political rights are precise, how is it that there are so many cases – at the national, regional and international levels – trying to figure out exactly what they mean?

Of course there are grey areas in our understanding of the right to health. The right gives rise to difficult concepts that require further elucidation. But the same can be said for many well-established human rights.

In my view there is a double standard here that we need to expose. A higher standard of ‘precision’ is demanded of the right to health than a number of other human rights and legal concepts.

It seems to me that the charge of imprecision and vagueness is often used as a convenient excuse for inaction. It is used by some states and others to say – “sorry, we would like to implement the right to health -- but it is so vague that we cannot.”

Ten years ago that argument had some legitimacy. But, over the last decade, our understanding of the right to health has come a long way and the so-called vagueness of the right to health should no longer be permitted as an excuse for inaction.

I want to close with some remarks – and a challenge – about maternal mortality. The challenge is not so much for health professionals, as for the human rights community. It is a challenge that health professionals might vigorously put to traditional human rights organisations and activists.

The scale of maternal mortality is catastrophic. You know the data. Every minute a woman dies in childbirth or from complications of pregnancy. That means well over 500,000 women a year. 95% are in Africa and Asia. A woman in sub-Saharan Africa faces a 1 in 16 risk of dying during pregnancy or childbirth, as compared to a 1 in almost 3000 risk in the developed world. There you have an example of the scandalous global health inequality I mentioned earlier. For every woman who dies as many as 30 others suffer chronic illness or disability.

Crucially, nearly all maternal mortality is avoidable. Most fatal obstetric complications could be treated with a few well-known technologies, namely emergency obstetric care. Of course, having the technical answers is not enough. Other forces can - and do - prevent widespread access to appropriate care.

In the 1990s, domestic violence was identified as a violation of human rights and this helped the global campaign against domestic violence gather momentum. By the same token, I suggest that the human rights community should be challenged to mount a global human rights campaign against maternal mortality. The human rights community must be urged to remonstrate and demonstrate about maternal mortality just as loudly as it complains about extra-judicial executions, arbitrary detention, unfair trials, and prisoners of conscience.

We have to get across the message that avoidable maternal mortality is a violation of the woman's right to health and life.

In some respects, this task might be more complex than it was in relation to domestic violence. After all, domestic violence is *always* a breach of human rights, whereas a few cases of maternal mortality are unavoidable.

Can I anticipate another complication?

Some lawyers will ask: if avoidable mortality is a violation of the right to health, who is the violator? This is an important question raising important issues.

It seems to me that in some cases there might be many with some responsibility for avoidable maternal mortality. Perhaps the family or community who discouraged the woman from seeking timely and appropriate medical help. Perhaps the health facility for not having the necessary care package, because of its own mismanagement, even corruption. Perhaps the government for providing insufficient funds. Perhaps the international community for providing the government with inadequate technical or financial assistance. And so on.

I think the answer to the lawyers is to insist – here is an extremely serious violation of the right to health. Who is responsible? We do not know - but that does not stop it from being a human rights violation – and this violation must be investigated *precisely to determine where responsibility lies*, and so as to better ensure that the appropriate policy changes are introduced as a matter of urgency.

The lawyers must not distract us from insisting: avoidable maternal mortality is a serious violation of the right to health. It must stop.

Earlier I argued for a policy approach to the right to health. The right must shape policy. If it does, the policy is likely to be more equitable and meaningful to disadvantaged individuals and communities. Equally, however, advocates of the right to health can use the traditional human rights techniques of ‘naming and shaming’, mass campaigns, and so on.

A global human rights campaign against avoidable maternal mortality should use both – the traditional well-trying human rights campaigning techniques, as well as the more nuanced policy analysis.

One reason why I suggest the time has come for a human rights campaign against avoidable maternal mortality is because such an initiative can draw upon the inspiring work already done by many who are active in this field. I am thinking of the tireless grassroots health workers and activists in every region of the world; my co-panellist today, Jane Cottingham, and her colleagues in WHO; Allan Rosenfield, Lynn Freedman and their colleagues at Columbia University; Ali Yamin, Rebecca Cook and many others too numerous to mention, some of them in this room -- I hope they will excuse me for not listing them here.

A human rights campaign against avoidable maternal mortality would inevitably lead to other crucial issues, not least the vital importance of constructing effective health systems that are accessible to all.

And this in turn leads to a crucial insight: an effective health system is a core social institution, no less than a court system or a political system. The right to a fair trial underpins a good court system. The right to vote underpins a democratic political system. And the right to health underpins our demand for effective health systems accessible to all.

Paul Hunt

25 September 2005