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# The Millennium Development Goals and the Right to the Highest Attainable Standard of Health

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# *International Lecture Series on Population and Reproductive Health*

## **Paul Hunt**

In 1998, Paul Hunt—a national of New Zealand—was elected by the UN to serve as an independent expert on the UN Committee on Economic, Social and Cultural Rights (1999–2002). Between 2001–2, at the request of Mary Robinson, then UN High Commissioner for Human Rights, he co-authored draft *Guidelines on Human Rights Approaches to Poverty Reduction*. In 2002, he was appointed UN Special Rapporteur on the right to the highest attainable standard of health—the first appointment to this new human rights mechanism. As Special Rapporteur, he endeavours to help States, and other actors, better promote and protect the right to the highest attainable standard of health. In his work, he has chosen to focus in particular on poverty and discrimination. An independent expert, he undertakes country missions and reports to the UN General Assembly and UN Human Rights Council. Paul has lived and/or undertaken human rights work in Europe, Africa, Asia, South America, the Middle East and South Pacific. In addition to his numerous UN reports on the right to the highest attainable standard of health, he has written extensively on economic, social and cultural rights in general, including *Reclaiming Social Rights: International and Comparative Perspectives* (1996), *Culture, Rights and Cultural Rights: Perspectives from the South Pacific* (co-ed, 2000), and *World Bank, IMF and Human Rights* (co-ed, 2003). He is a Professor in law, and member of the Human Rights Centre, at the University of Essex (England) and Adjunct Professor at the University of Waikato (New Zealand).

# The Millennium Development Goals and the Right to the Highest Attainable Standard of Health

**T**he right to the highest attainable standard of health does not provide magic solutions to complex health issues, any more than do ethics or economics. Nonetheless, this human right has a crucial, constructive role to play. Health policy makers and practitioners who ignore this fundamental human right are failing to use a powerful resource that could help to realise their professional objectives.<sup>1</sup>

At the international level, the right to health was first articulated in the Constitution of the World Health Organisation in 1946. Subsequently, it was enshrined in several legally binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, as well as many national constitutions.<sup>2</sup>

To its credit, Nigeria has ratified most of the key international human rights treaties that encompass the right to the highest attainable standard of health, although there is much work to be done to incorporate these treaties into domestic law. For example, the domestic incorporation of the Convention on the Elimination of All Forms of Discrimination against Women would be a major advance. Also, the constitutional protection of the right to health could and should be stronger. However, Nigeria has in place some impressive federal health policies. As in most countries, the vital challenge remains implementation: how to deliver the treaty commitments and national policies?

Although first articulated long ago, the right to health remained little more than a slogan for more than 50 years. Not until 2000 did an authoritative understanding of the right emerge when the UN Committee on Economic, Social and Cultural Rights, in close collaboration with WHO and many others, adopted General Comment 14.<sup>3</sup>

This substantive instrument confirms that the right to health not only includes access to medical care, but also the underlying determinants of health, such as safe water, adequate sanitation, a healthy environment, health-related information (including on sexual and reproductive health), and freedom from

discrimination. The right has a pre-occupation with disadvantaged groups, participation and accountability. It demands that health-related services be evidence-based, respectful of cultural difference, and of good quality. Moreover, it places a responsibility on high-income countries to help developing countries deliver the right to health to their people.<sup>4</sup>

Importantly, the international right to the highest attainable standard of health is subject to progressive realisation and resource availability. It does not impose the absurd demand that the right to health be realised immediately, overnight.<sup>5</sup> Nor does it expect Nigeria in 2007 to be doing as well as the United Kingdom; obviously, today Nigeria has fewer resources than the UK. Rather, international human rights law requires that a State move as expeditiously and effectively as possible towards the realisation of the right to the highest attainable standard of health, with particular regard to those living in poverty and other disadvantaged groups and individuals. These steps must be deliberate, concrete and targeted. And they must, of course, take into account the resources—national and international—at the State's disposal.<sup>6</sup>

In my experience, many countries are most definitely not doing all they reasonably can, within their available resources, to progressively realise the right to the highest attainable standard of health, especially for those living in poverty. It is imperative that they be held to account for these shortcomings—more on accountability later.

Although General Comment 14 leaves numerous questions unanswered, it remains groundbreaking and marks the moment when the right to health ceased to be a slogan and became an important tool for all health policy makers and practitioners.

As UN Special Rapporteur on the right to the highest attainable standard of health, I try to make the right to health—and General Comment 14—more specific, accessible, practical and operational. Informed by numerous consultations with a wide range of health workers, my numerous reports—all of which are public—focus on poverty, discrimination and the right to health.<sup>7</sup> Some reports look at the right to health in particular countries, such as Uganda, Mozambique, Peru, Romania and Sweden. Some focus on special situations, such as Guantanamo Bay, as well as the war in Lebanon and Israel during mid-2006.<sup>8</sup> One focuses on the World Trade Organisation. Several address broad right-to-health issues, such as maternal mortality, mental disability, access to medicines, sexual and reproductive health rights, and the skills drain of health professionals—a perverse subsidy from the poor to the rich that undermines the right to health of those living in sending countries, including Nigeria.

All these reports and interventions look at issues through the right-to-health lens. In this way, they develop an analytical framework for ‘unpacking’ the right to health. This framework deepens understanding of complex health issues and helps to identify practical policy and programmatic responses, including measures that are meaningful to disadvantaged communities and individuals.

### **New skills and techniques**

One of the most pressing challenges is the integration of the right to health in all national and international health-related policies.

After all, if the right to health is neither an established feature of domestic law, nor integrated into national health-related policies, what useful purpose is it really serving?

Thus, the right to health should be integrated into those policies that are designed to realise the Millennium Development Goals, as well as poverty reduction and development policies, such as Nigeria’s National Empowerment and Development Strategy and corresponding initiatives at the state-level.

After a long process of consultation, the UN Office of the High Commissioner for Human Rights has recently published guidelines to help States integrate human rights into their poverty reduction strategies.<sup>9</sup>

To achieve this integration, the traditional human rights methods and techniques—‘naming and shaming’, letter-writing campaigns, taking test cases, slogans, and so on—are not enough.

If I visit a Minister of Health and talk in slogans and threaten test cases and letter-writing campaigns, obviously the Minister will show me the door. And rightly so. These traditional human rights methods are sometimes still needed, but new techniques and skills are also required, such as indicators, benchmarks, impact assessments and budgetary analysis. Moreover, these new methods are taking shape, reflecting the growing maturity of the health and human rights movement.<sup>10</sup>

Today, for example, it is widely recognised that a system of indicators and benchmarks is essential if we are to measure the progressive realisation of the right to health. Several specialized agencies, civil society organisations, academics and others are contributing to the development of appropriate indicators and benchmarks in the specific context of the right to health and other human rights.<sup>11</sup> One of my recent reports sets out a human rights-based approach to health indicators.<sup>12</sup>

Also, a range of actors are now developing human rights—and right-to-health—impact assessments.<sup>13</sup> If the right to health is to be integrated into policies, a methodology is needed to help policy makers anticipate the likely

impact of a projected policy on the enjoyment of the right to health, so that, if necessary, adjustments can be made to the proposed policy. Last year, I co-authored a UNESCO-funded paper that introduces some of the growing literature on this topic and sets out, for discussion, a draft methodology for right-to-health impact assessments.<sup>14</sup>

The health and human rights movement is grappling with other difficult issues and questions, for example: when formulating health policies, which trade-offs are permissible and impermissible from the perspective of the right to health? Given finite budgets, how should Ministers of Health prioritise, in a manner that is respectful of the right to health, among competing objectives?<sup>15</sup> The health and human rights movement is developing the techniques and skills that will enable it to make a constructive contribution to these important, complex discussions.

In short, there is a new maturity about the health and human rights movement. ‘Naming and shaming’, test cases and slogans all have a vital role to play in the promotion and protection of the right to health, but so do indicators, benchmarks, impact assessments, budgetary analysis, and the ability to take tough policy choices in a manner that is respectful of international human rights law and practice.

Unfortunately, some States, international organisations, civil society groups and commentators seem oblivious to these new, encouraging developments.

### **Is the international right to health merely aspirational? Is it too vague to be implemented?**

Some argue that the right to the highest attainable standard of health is only aspirational. They usually add that it is too vague—too imprecise—to be taken seriously.

Let us be clear: the international right to the highest attainable standard of health gives rise to legally binding obligations on States. Whether or not the relevant treaty is incorporated into domestic law, it places legally binding responsibilities on the State authorities.

As for the charge of vagueness, in fact, the right to health is as precise (if not more so) as concepts like reasonableness, fairness, justice, democracy and freedom—all of which routinely shape policy. Some of these concepts regularly come before the courts for adjudication.

Moreover, how precise are the well-established civil and political rights? How precise is freedom of expression, with its complex array of lawful limitations? How precise is the right to privacy? As for the prohibition against torture, 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—exploring, clarifying and confirming 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, the right to health is the victim of a double standard. 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 is often an excuse for inaction. Some States, and others, 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 our understanding of the right to health has come a long way in recent years and its so-called vagueness can no longer be permitted as an excuse for inaction—neither by States, nor international organisations, nor civil society, nor anybody else.

### **Uganda, neglected diseases and the right to health**

In 2005, I was pleased to accept an invitation from the Government of Uganda to visit and prepare a report on neglected diseases.<sup>16</sup>

By neglected diseases I refer to those illnesses that are mainly suffered by poor people in poor countries. They are also known as ‘poverty-related’ or ‘tropical’ diseases. In Uganda they include river blindness, sleeping sickness and lymphatic filariasis. Like elsewhere in West Africa, neglected or poverty-related diseases are also endemic in parts of Nigeria.

According to WHO, the global “health impact of ... neglected diseases is measured by severe and permanent disabilities and deformities in almost 1 billion people”.<sup>17</sup> Despite the astonishing scale of this suffering, these terrible diseases have historically attracted little health research and development. Why? Because those afflicted invariably have negligible purchasing power. The record shows that, hitherto, the market has failed them.<sup>18</sup>

Neglected diseases mainly afflict neglected communities. Importantly, 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.

Examining Uganda’s neglected diseases through the lens of the right to health underlined the importance of a number of policy responses.

For example, it underlined the imperative of developing an *integrated* health system responsive to local priorities. Vertical health interventions that

focus on only one particular disease can actually weaken the broader health system. An integrated system is essential.

In Uganda, village health teams are urgently needed to identify local health priorities. Where such teams already exist, they need strengthening. Village health teams often know the neglected diseases afflicting their villages much better than a health official in the regional or national capital.

Of course, if Uganda is to tackle neglected diseases, more health workers are essential. Additionally, however, incentives are needed to ensure that health workers are willing to serve the remote neglected communities especially afflicted by neglected diseases.

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.

The right to health requires that effective monitoring and accountability devices be established, not with a view to blame and punishment, but with a view to identifying what works (so it can be repeated) and what does not (so it can be revised). This ‘constructive accountability’ is one of the most important features of the right to health—and I will come back to it later in relation to the Millennium Development Goals.<sup>19</sup>

In Uganda, existing parliamentary and judicial accountability mechanisms are not working in relation to neglected diseases. In my report I suggest that one way of enhancing accountability would be for the Ugandan Human Rights Commission to establish a Unit responsible for monitoring initiatives relating to these diseases. I also recommend that the Unit should go beyond monitoring and hold all actors to account. Adopting an evidence-based approach, it should endeavour to assess which initiatives are working and which are not—and if not, why not. Using the right to health as a yardstick, the Unit should consider the acts and omissions of all actors bearing on neglected diseases in Uganda, and report annually to Parliament. Significantly, the Unit should monitor and hold to account both national and international actors in both the public and private sectors.

The issues I was confronted with in Uganda were symbolised by a girl I met in a camp for internally displaced people where she lived in squalid conditions. She was suffering from disfiguring lymphatic filariasis. At school, she was mocked, bullied and unsupported. She could not stand the abuse and

left school. This young woman was the victim of multiple human rights violations. As my report tries to show, the right to health signals the policies that could and should address her desperate injustice.

A few months ago, I returned to Uganda to see whether or not the recommendations set out in my earlier report had been implemented. I found that the Ministry of Health was adopting a much more integrated approach in relation to neglected diseases. Also, the Ugandan Human Rights Commission had established a Unit to monitor neglected diseases and the right to health.<sup>20</sup>

For present purposes, however, 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, you could identify these policy proposals for neglected diseases without reference to the right to health—just as you could construct a good court system without reference to the right to a fair trial. But the right to health can help to identify good proposals and, where they already exist, the right can reinforce them.

The same applies in relation to policies that are designed to achieve the Millennium Development Goals (MDGs).

### **Millennium Development Goals**

The Millennium Development Goals represent one of the most important strategies in the United Nations. So far as I am aware, no other set of international commitments and policy objectives has attracted such strategic, systemic and sustained attention since the foundation of the world organisation. The Goals have much to offer human rights, just as human rights have much to offer the Goals.

Although the MDGs have generated a great deal of literature, human rights receive relatively slight attention in this rich material.<sup>21</sup> This is especially surprising given the close correspondence between the Goals and a number of human rights, including the right to the highest attainable standard of health. As Kofi Annan, the former UN Secretary-General, put it: “economic, social and cultural rights are at the heart of all the millennium development goals”.<sup>22</sup>

My main task today is to introduce the relationship between the Goals and human rights—it is not to review Nigeria’s progress towards the Goals.

I have the firm impression, however, that within the Nigerian Government there is a serious, high-level, political commitment to their achievement, reflected by, for example, the appointment—and re-appointment—of the Senior Special Assistant to the President on the Millennium Development Goals. I am full of admiration for the vigour and determination with which

the Senior Special Assistant has tackled her extremely challenging task.

However, it has to be said that there is still a very long way to go if all the Goals are to be achieved in Nigeria by 2015. The data are especially alarming in the northeast and northwest of the country.

I would like to suggest that the proper consideration of the right to health, and other human rights, will help Nigeria achieve the Goals by 2015.

### **Health-related Millennium Development Goals**

One of the most striking features of the MDGs is the prominence they give to health. Of the eight MDGs, four are directly related to health: Goal 4 (to reduce child mortality); Goal 5 (to improve maternal health); Goal 6 (to combat HIV/AIDS, malaria and other diseases); and Goal 7 (to ensure environmental sustainability, including reducing by half the proportion of people without sustainable access to safe drinking water).

Two other MDGs are closely related to health: Goal 1 (to eradicate extreme poverty and hunger); and Goal 8 (to develop a global partnership for development).<sup>23</sup> Both of the remaining goals (achieving universal primary education and empowering women—Goals 2 and 3) have a direct impact on health. It is well documented that educated girls and women provide better care and nutrition for themselves and their children.

Health is central to the MDGs because it is central to poverty reduction and development. Good health is not just an outcome of poverty reduction and development: it is a way of achieving them. But it is also more than that. As we have seen, international law—and numerous national constitutions—recognizes the human right to the highest attainable standard of physical and mental health.

### **What does the right to health bring to the Millennium Development Goals?**

The answer to this question has been signalled by the previous comments on a right-to-health approach to neglected diseases. A right-to-health approach to the Goals resonates with the right-to-health approach to neglected diseases. But the question ‘What does the right to health bring to the Millennium Development Goals?’ also demands some additional responses.

#### *Helping to deliver the Millennium Development Goals to the disadvantaged and marginal*

The health-related Goals are framed in terms of societal averages, for instance, to reduce the maternal mortality ratio by three-quarters (Goal 5). But the average condition of the whole population can be misleading: improvements in average health indicators can mask a decline for some disadvantaged

groups. Human rights require that, so far as practical, all relevant data are disaggregated on the prohibited grounds of discrimination.<sup>24</sup> In this way it becomes possible to monitor the situation of marginal groups—women living in poverty, indigenous peoples, minorities and so on—and design policies that specifically address their disadvantage.<sup>25</sup>

This is one of the areas in which the right to health has a particular contribution to make to the achievement of the health-related Goals. Because of the special attention that it has devoted to these issues over many years, the international human rights system has a wealth of experience on non-discrimination and equality that can help to identify policies that will deliver the health-related Goals to all individuals and groups, including those that are most disadvantaged.

### *Enhancing participation*

Participation is an integral feature of the right to health. The right to participate means more than free and fair elections. It also extends to the active and informed participation of individuals and communities in decision-making that affects them, including decisions that relate to health. In other words, the right to health attaches great importance to the processes by which health-related objectives are achieved, as well as to the objectives themselves.

While strategies for development and poverty reduction must be country-driven, country ownership should not be understood narrowly to mean ownership on the part of the Government alone. The strategy has to be owned by a wide range of stakeholders, including those living in poverty. Of course, this is not easy to achieve and takes time. Innovative arrangements are needed to facilitate the participation of those who are usually left out of policy making. Moreover, these arrangements must respect existing local and national democratic structures.

While the MDG initiative is highly commendable, it exhibits some of the features of the old-style, top-down, non-participatory approach to development. A greater recognition of the right to health will reduce these technocratic tendencies, enhance the participation of disadvantaged individuals and communities, and thereby improve the chances of achieving the health-related Goals for all.

### *Ensuring vertical interventions strengthen health systems*

The right to health requires the development of effective, inclusive health systems of good quality. For the most part, the health-related MDGs are disease—specific or based on health status—malaria, tuberculosis, HIV/

AIDS, maternal health and child health—and they will probably generate narrow vertical health interventions. Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. By drawing off resources and overloading fragile capacity, vertical inventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system. A proper consideration of the right to health, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems available to all.

#### *More attention to health workers*

Health workers—doctors, nurses, midwives, technicians, administrators, and so on—have an indispensable role to play in relation to the health-related MDGs. However, human resources are in crisis in many health systems. Unless the plight of health workers is given the most serious attention, it is hard to imagine how the health-related MDGs will be achieved in many countries. The difficult situation of health workers bears closely upon the right to health. For example, fair terms and conditions of employment for health workers is a right to health issue. As already observed, the skills drain of health professionals from South to North is also a right to health issue, as is the rural-to-urban migration of health professionals within a country. The South to North skills drain is inconsistent with Goal 8 (a global partnership for development) because here we have northern policies draining the pool of health professionals away from developing countries. The right to health can help to ensure that these complex issues concerning health professionals, that impact directly upon the achievement of the health-related MDGs, receive the careful attention they deserve.

#### *Sexual and reproductive health*

The MDGs encompass sexual and reproductive health issues, such as maternal health, child health and HIV/AIDS. In 2005, universal access to reproductive health for all by 2015 became a new target under Goal 5.

According to the United Nations, “sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.<sup>26</sup> In 2004, I explored the scope of the rights to sexual and reproductive health in the context of the Cairo and Beijing world conferences of the 1990s.<sup>27</sup> I will not repeat that analysis here, but confine myself to three issues.

*First*, the right to health includes women and men having the freedom to decide if and when to reproduce. This encompasses 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 to go safely through pregnancy and childbirth.

*Second*, adolescents and young people under 25 years of age are especially vulnerable to sexual and reproductive ill-health. In many countries, adolescents lack access to essential and relevant information and health services. Yet, as the global data confirm, their needs are acute. An estimated 16% of all new HIV infections occur among those under 15, while 42% of new infections occur among those aged 15–24. Every year there are 100 million new, largely curable, reported cases of sexually transmitted infections among adolescents.

The right to health places an obligation on a State to make sexual and reproductive health information available and accessible to adolescents.

*Third*, the global scale of maternal mortality is catastrophic. Every minute a woman dies in childbirth or from complications of pregnancy. That means well over 500,000 women each year.<sup>28</sup>

These deaths reveal chronic, entrenched global health inequalities. The burden of maternal mortality is borne disproportionately by developing countries: 95% of these deaths occur in Africa and Asia.<sup>29</sup> In Sub-Saharan Africa, 1 in 16 die in pregnancy or childbirth, compared with 1 in almost 30,000 in Sweden.<sup>30</sup>

Crucially, most maternal deaths are preventable.<sup>31</sup>

For every woman who dies from obstetric complications, approximately 30 more suffer injuries, infections and disabilities, often leading to stigma, discrimination and deepening poverty.<sup>32</sup>

Pregnant women survive where they are able to access safe reproductive and maternity health care services around the clock. But eliminating preventable maternal mortality is not just a question of access to medical care. Women's health is shaped by a wide-range of factors that lie beyond the health sector, including gender equality and access to education. Maternal mortality demands collaboration across a wide-range of sectors and ministries.

There are several human rights that bear closely upon maternal mortality, most obviously the rights to health and life, as well as non-discrimination, equality, and international assistance and cooperation.<sup>33</sup>

We have to grasp that maternal mortality is not just a personal tragedy. It is not just a development, humanitarian and health issue. Maternal mortality is a human rights issue.

The scale of maternal mortality is larger than some of the human rights issues that, for many years, have attracted much of the attention of well-

established human rights non-governmental organisations. For example, several of these organisations campaign against the death penalty. Amnesty International reports that in 2006 about 1,600 people under sentence of death were executed.<sup>34</sup> This is almost certainly an underestimate, so let's assume this figure should be multiplied tenfold to 16,000.

In the same period, how many maternal deaths were there? About 500,000. And most of them were preventable.

The death penalty is an extremely serious human rights issue that fully deserves the human rights attention it receives. But maternal mortality is also an extremely serious human rights problem and yet it has not received the attention it deserves from the human rights community.

The time has come for established human rights non-governmental organisations to recognise that maternal mortality is a human rights catastrophe on a massive scale. It is time for them to campaign against maternal mortality just as vigorously as they have campaigned against the death penalty, disappearances, extra-judicial executions, torture, arbitrary detention, and prisoners of conscience.

Some will ask: if a preventable maternal mortality might be a violation of the right to health, who is the alleged violator? The international community for failing to do all it promised to help the State in question? The State for failing to formulate and implement the most effective maternal health policies within available resources? The health facility for alleged mismanagement or corruption? The local community for inadequate timely support for the woman who died? Or perhaps a combination of these—and other—factors.

The straight answer is that we do not always know, at first sight, who is responsible for a preventable maternal death. But that does not stop it from being a profoundly important human rights issue that must be investigated *precisely to determine where responsibility lies*, and so as to better ensure that the appropriate policy and other changes are introduced as a matter of urgency.

Of course, if there has been a breach of human rights then formally the State will be responsible. But an investigation could and should go beyond this formal, legal position and shed light on where *operational* responsibility lies. This is akin to what is sometimes needed in relation to alleged violations of civil and political rights, such as systemic, widespread 'disappearances'.

In conclusion, recognising maternal mortality for what it is—a human rights catastrophe on a massive scale—is not going to solve a complex health problem. The contribution of human rights must never be exaggerated. But neither must it be ignored.

### *Reinforcing Goal 8: a global partnership for development*

As already suggested, developed states have some responsibilities towards the realisation of the right to health in developing countries. These responsibilities arise from the provisions relating to international assistance and cooperation in international human rights law. Importantly, international assistance and cooperation should not be understood as meaning only financial and technical assistance: it also includes the responsibility of developed states to work actively towards an international order that is conducive to the elimination of poverty and the realisation of the right to health in developing countries.

Like some other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, in principle, international assistance and cooperation requires that all those in a position to assist should, first, refrain from acts that make it more difficult for the poor to realize their right to health and, second, take measures to remove obstacles that impede the poor's realisation of the right to health.

The human rights concept of international assistance and cooperation resonates strongly with Goal 8, as well as the principles of global equity and shared responsibility that animate the Millennium Declaration. However, in addition, because it is enshrined in binding international human rights law, the human rights concept of international assistance and cooperation provides *legal reinforcement* to Goal 8, as well as the Declaration's principles of global equity and shared responsibility.

Shortly, I will return to the vital issue of developed states' accountability in relation to Goal 8.

### *Strengthening accountability*

International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window-dressing. Accordingly, a human rights—or right to health—approach emphasizes obligations and requires that all duty-holders be held to account for their conduct.

All too often, “accountability” is used to mean blame and punishment.<sup>35</sup> But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and institutions are working, which are not, and why, with the objective of improving the realisation of the right to health for all. Such an accountability device has to be effective, transparent and accessible.

Accountability comes in many forms. At the international level, human rights treaty bodies provide an embryonic form of accountability, while at the national level a health commissioner or ombudsman may provide a degree of accountability. A democratically elected local health council is another type of accountability mechanism. Administrative arrangements, such as publicly available health impact assessments, may also enhance accountability. In relation to a human right as complex as the right to health, a range of accountability mechanisms is required and the form and mix of devices will vary from one State to another.

We have to be frank and recognise that the accountability mechanisms in relation to the Goals are weak. Human rights, including the right to health, can strengthen this accountability. Existing human rights accountability mechanisms can consider the adequacy of what States are doing to achieve the Goals. At the country level, a national human rights institution—or other independent body depending on the country context—could establish an MDG monitoring and accountability unit. At the international level, the examination by a human rights treaty body of a State's periodic report could consider those MDGs falling within the treaty body's mandate. On country mission, special rapporteurs could explore those Goals falling within their mandates.

Human rights do not provide a neat standard-form accountability mechanism that can be applied to the MDGs. More thought needs to be given to devising appropriate, effective, transparent and accessible accountability mechanisms in relation to the MDGs. If such mechanisms are not devised, the Goals will lack an indispensable feature of human rights—and, more importantly, the chances of achieving the MDGs will be seriously diminished.

#### *Strengthening accountability for Goal 8*

While the accountability mechanisms in relation to all the MDGs are weak, they are especially feeble in relation to Goal 8 (a global partnership for development). Some developed states have published reports on their progress towards Goal 8 and such self-monitoring is very welcome. It does not, however, constitute an adequate form of accountability.

There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.<sup>36</sup> Unfortunately, the Millennium Development initiative tends to confirm this perception. The burden of MDG reporting

falls mainly upon low- and middle-income countries. This imbalance is inconsistent with the principles of reciprocity, shared responsibility and mutual accountability upon which the United Nations Millennium Declaration and its Goals are based.

This imbalance is especially regrettable because of the crucial importance of Goal 8 to developing countries, many of which suffer from acute impoverishment on a national scale. For them it is not a matter of greater efficiencies or fairer distribution among their citizens (although these considerations are often important), it is a question of an alarming shortage of resources and grossly inadequate budgets. In other words, Goal 8 is absolutely vital for developing countries.

From the point of view of human rights, including the right to health, it is imperative that the accountability arrangements in relation to Goal 8 be strengthened. If the international community is not able to agree on effective, transparent and accessible accountability mechanisms regarding Goal 8, developing countries may wish to establish their own independent accountability mechanism regarding the discharge of developed states' commitments under Goal 8.

I attach particular importance to accountability in relation to Goal 8 because, for many developing countries, achieving the health-related MDGs depends to a large degree upon developed states honouring their commitments under Goal 8.

To their credit, many developed states are endeavouring to deliver their Goal 8 commitments. For example, the Paris Club debt relief, worth some US\$18 billion to Nigeria, resonates with the creditor States' Goal 8 commitments. Also, Partnerships for Transforming Health Systems, an important programme of assistance to Nigeria funded by the Department for International Development, chimes with the UK's Goal 8 commitments.

Such commendable initiatives, however, do not diminish the need for effective, transparent and accessible accountability mechanisms for developed States' commitments under Goal 8.

For their part, developed States are right to call for greater accountability in developing States. But this is a two-way street. Greater accountability is also urgently needed in relation to developed countries' international pledges and commitments that are so vital to those living in poverty in low and middle-income states.

### **Conclusion: the complementary relationship between health and human rights**

I have not considered all the issues where human rights and the Millennium Development Goals intersect and reinforce each other.

Human rights, for example, have a crucial role to play in relation to Goal 6—halting and reversing the spread of HIV/AIDS. Stigma and discrimination are critical factors in the spread of HIV/AIDS because they undermine prevention, treatment and care. Women and girls are especially vulnerable to HIV/AIDS when they lack control over their bodies and sexual lives—in other words, when their human rights are denied. On public health and human rights grounds, it is imperative that prevention, treatment and care strategies target at-risk populations, including commercial sex workers and their clients, and men who have sex with men. It is wrong on public health, human rights and humanitarian grounds when hospitals refuse to treat people living with HIV/AIDS. Human rights can help States achieve the HIV/AIDS Millennium Development Goal, just as they have a contribution to make in the struggle against neglected diseases and maternal mortality.

Obviously, the right to health depends upon health workers who enhance public health and deliver medical care. Equally, the classic, traditional objectives of the health professions can benefit from the new, dynamic discipline of human rights. Health workers can use the right to health to help them devise equitable policies and programmes that benefit the most disadvantaged; strengthen health systems; place important health issues higher up national and international agendas; secure better coordination across health-related sectors; raise more funds from the Treasury; leverage more funds from developed to developing countries; in some countries, improve the terms and conditions of those working in the health sector; and so on. In short, the right to the highest attainable standard of health is an asset and ally, which is at the disposal of all health workers.<sup>37</sup>

I urge health and human rights workers to recognise their common ground and to collaborate together in our collective struggle to achieve all the Millennium Development Goals and the elimination of that human rights catastrophe—preventable maternal mortality.

## Publications by the author

<sup>1</sup> For the sources and content of the right to the highest attainable standard of health, see E/CN.4/2003/58 (13 February 2003). The full formulation of the right is the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Here, for convenience, I will use the shorthand “right to the highest attainable standard of health” or “right to health”.

<sup>2</sup> See E. D. Kinney and B. A. Clark, “Provisions for Health and Health Care in the Constitutions of the World”, 37 *Cornell International Law Journal* 285, 2004.

<sup>3</sup> General Comment 14, E/C.12/200/4 (11 August 2000).

<sup>4</sup> For an accessible guide, designed for non-governmental organisations, to the right to health, see J. Asher, *The Right to Health: A Resource Manual for NGOs*, Commat/AAAS, 2004.

<sup>5</sup> However, the right to health gives rise to some obligations of immediate effect that are not subject to progressive realisation and resource availability. For example, a State has an immediate obligation to ensure that its health-related laws, policies, programmes and projects are non-discriminatory.

<sup>6</sup> See General Comment 14, from paragraph 30.

<sup>7</sup> For all my reports and press releases, see the Right to Health Unit at the University of Essex, [http://www2.essex.ac.uk/human\\_rights\\_centre/rth/](http://www2.essex.ac.uk/human_rights_centre/rth/), viewed 14 August 2007.

<sup>8</sup> Both reports were co-authored with other UN independent human rights experts.

<sup>9</sup> *Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies*, OHCHR, available on the website of OHCHR.

<sup>10</sup> For a discussion of some of these issues, see A. Yamin, “The Future in the Mirror”, 27(4) *Human Rights Quarterly* 2005.

<sup>11</sup> For example, the Office of the High Commissioner for Human Rights; also, World Health Organisation, <http://www.who.int/whosis/en/index.html> viewed 14 August 2007.

<sup>12</sup> UN Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and

mental health, (3 March 2006), E/CN.4/2006/48.

<sup>13</sup> For example, Norwegian Agency for Development Cooperation, *Handbook in Human Rights Assessment: State Obligations, Awareness & Empowerment* (2001); Rights and Democracy, Human Rights Impact Assessments for Foreign Investment Projects (2007); Humanist Committee for Human Rights (HOM), *Health Rights of Women Assessment Instrument* (2006).

<sup>14</sup> G. MacNaughton and P. Hunt, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health*, (2006), available at [http://www2.essex.ac.uk/human\\_rights\\_centre/rth/](http://www2.essex.ac.uk/human_rights_centre/rth/) viewed 14 August 2007.

<sup>15</sup> For a preliminary discussion, see the latest report (dated 8 August 2007) to the General Assembly of the UN Special Rapporteur on the right to the highest attainable standard of health, A/62/214, chapter II.

<sup>16</sup> The report is E/CN.4/2006/48/Add.2, dated 19 January 2006.

<sup>17</sup> M. Kindhauser, (ed) *Communicable diseases 2002: Global defence against infectious disease threat*, Geneva, WHO, 2003 (WHO/CDS/2003.15).

<sup>18</sup> In recent years, the amount of research and development on neglected diseases has increased, see M. Moran and others, *The New Landscape of Neglected Disease Drug Development*, The Wellcome Trust, 2005.

<sup>19</sup> See L. P. Freedman, “Human rights, constructive accountability and maternal mortality in the Dominican Republic”, *International Journal of Gynaecology and Obstetrics*, vol. 82, 2003, pp. 111-114.

<sup>20</sup> See A/HRC/4/28/Add.3 dated 21 March 2007.

<sup>21</sup> There are some notable exceptions eg Interim Report of Task Force 4 on Child Health and Maternal Health, 19 April, 2004; Ethical Globalization Initiative, Comments on Interim Report of Task Force 5 Working Group on HIV/AIDS; Grow Up Free from Poverty Coalition, 80 Million Lives, 2003; Philip Alston, “Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals”, *Human Rights Quarterly*, vol. 27.3 (2005), pp. 755-829.

- 22 A/56/326, dated 6 September 2001, para. 202.
- 23 For example, one of the MDG 8 targets is to provide affordable essential drugs in developing countries.
- 24 The twin principles of non-discrimination and equality are among the most fundamental elements of international human rights, including the right to health. Both principles are enumerated and elaborated in numerous international instruments.
- 25 Country-level situational analyses may identify marginal groups that are not expressly included in the grounds of discrimination prohibited under international human rights law but which nonetheless demand particular attention.
- 26 E/CN.4/2003/RES/2003/28, dated 22 April 2003.
- 27 E/CN.4/2004/49, dated 16 February 2004.
- 28 A “maternal death” is defined, according to the Tenth International Classification of Diseases, as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”
- 29 UNFPA web site, <http://www.unfpa.org/mothers/statistics.htm>, viewed 14 August 2007.
- 30 C. Ronsmans, et al. “Maternal Mortality: Who, When, Where and Why”, *The Lancet* [online] [www.thelancet.com](http://www.thelancet.com), viewed 14 August 2007, pp.2.
- 31 *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2000*, WHO, 2004.
- 32 UNICEF statistics, 2003, reported in S. Bernstein, *Public Choices, Private Decisions: Sexual and Reproductive Health and MDGs*, Millennium Project, 2006.
- 33 Those who have written on maternal mortality and human rights include: L.P. Freedman, “Human Rights, Constructive Accountability and Maternal Mortality in the Dominican Republic: A Commentary”, *International Journal of Gynaecology and Obstetrics*, Volume 82, 2003, 111-114; R. J. Cook, M.B. Dickens, et al, *Advancing Safe Motherhood Through Human Rights*, Geneva, World Health Organization, 2001; A. Yamin, & D. Maine, “Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations”, *Human Rights Quarterly*, Volume 21, Issue 3, 1999, 563-607. Apart from those contributing to a deepening human rights analysis of maternal mortality, many others have contributed in other congruent ways e.g. the political analysis in J. Shiffmann and A. Valle, “Political History and Disparities in Safe Motherhood Between Guatemala and Honduras”, *Population and Development Review* 32(1): 53-80 (March 2006).
- 34 Amnesty International, *Facts and Figures on the Death Penalty*. <http://web.amnesty.org/pages/deathpenalty-facts-eng> viewed 14 August 2007.
- 35 Freedman, 2003.
- 36 UNDP, Bureau for Development Policy, “Is MDG 8 on track as a global deal for human development?”, prepared by J. Vandenmoortele, K. Malhotra and J. A. Lim (New York, 2003), pp.2.
- 37 See BMA, *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, BMA/Zed Books, 2001.

## *About the Foundation*

The John D. and Catherine T. MacArthur Foundation is a private, independent grantmaking institution dedicated to building a more just and sustainable world. Through the support it provides, the Foundation fosters the development of knowledge, nurtures individual creativity, strengthens institutions, helps improve public policy, and provides information to the public, primarily through support for public interest media. With assets of more than \$6.4 billion, MacArthur makes grants and low-cost loans totaling approximately \$225 million each year. For more information or to sign up for the Foundation's free electronic newsletter, please visit [www.macfound.org](http://www.macfound.org).

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Grantmaking in this area reflects a comprehensive approach to reproductive and sexual health and rights, one that places women's well-being at the center of population policy and emphasizes the rights of individuals to determine and plan family size. Through its offices in India, Mexico, and Nigeria, the Foundation makes grants that support efforts to reduce maternal mortality and morbidity and to advance the sexual and reproductive health and rights of young people in these three countries.

MacArthur's grantmaking to reduce maternal mortality strives to increase resources for women's health and to improve the quality and reach of publicly provided reproductive health services. Most of MacArthur's grantmaking to reduce maternal mortality and morbidity is carried out in India, Nigeria, and Mexico, where the Foundation maintains offices. The Foundation also funds selected international organizations in the population and reproductive health field whose work promotes innovation in policy, programs and services.

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