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Ladies and Gentlemen,

Thank you, Richard Manning, for your kind introduction. It is a pleasure to participate in this gathering and to join so many prominent and forward-looking personalities in new thinking on the health of nations. I would like to thank the organizers for inviting me, and giving me an opportunity to speak to you on Health, Human Rights and Development, a topic which is central to my work today as Head of the Ethical Globalization Initiative. My first message to you is simple: health, human rights and development are inextricably linked, and the linkages are both multiple and multi-causal.

First, let us take health and development: the work of the Commission on Macroeconomics and Health¹, under the leadership of my friend and Columbia University colleague Jeffrey Sachs, has demonstrated to all of us that health is at the heart of development. ²Ill health is both a cause and a consequence of poverty and under-development. Historically, disease and poverty go hand in hand, and improvements in nutrition, sanitation and health care are simply central to social and economic development—as in the industrial revolution, which was preceded by advances in agriculture, nutrition and sanitation.³ In particular, it is increasingly clear that a high burden of infectious diseases, as in Africa, is a major barrier to development. Happily, the central role of health in development is fully recognized in the recent Millennium Declaration, which includes at least three explicitly health-related goals. I will return to this point later.

Next, let us look at the relationship between health and human rights. Again, the synergies are unmistakable. Human rights violations—such as violence, discrimination and stigma—are both a cause and a result of ill health, as in the AIDS pandemic. The relationship between health and the so-called economic and social rights—the rights to adequate food, housing, water, social security, education, to name just a few—are glaring. But the connections with civil and political rights, such as the right to life, the right to freedom of expression, freedom of press, gender equality and freedom from discrimination, are also unmistakable. This is a central aspect of my work with the Ethical Globalization Initiative. Under the motto “Realizing Rights”, we are deeply committed to exploring and promoting a human rights and gender sensitive approach to the fight against HIV/AIDS. I will be giving you specific examples of this approach, and how it is beginning to be implemented in very practical ways in Africa. I would also like to discuss with you just what donor countries could and should do to support a strong gender approach to both treatment and prevention of this disease.

But first, let us complete our overview of the linkages among health, human rights and developments, by looking at the relationship between human rights and development. Since the 1990s, the concepts of poverty and development have moved away from a

¹ See Final Report of the Commission on Macroeconomics and Health, at www.cmhealth.org

² See Jeffrey Sachs, inaugural lecture “Global Health and the Economy”, January 20, 2004, at www.globalhealth.columbia.edu/ghss/ghsss_sched.html

³ Id

narrow emphasis on income poverty (the \$1 or \$2 a day thresholds) towards a fuller concept of human well being, human development and human security, as exemplified in the United Nations Human Development Report or, just last year, in the excellent report of the Commission on Human Security. Crucially, poverty is understood to mean not just low income but a deprivation of human capabilities, including through lack of access to health and education, as best developed by Amartya Sen. As a reminder, it is estimated that 2.8 billion people live in poverty, including 1.2 billion in extreme poverty, a majority of them women and children.

Let me pose a question I was often asked by the media during my five years as United Nations High Commissioner for Human Rights: What, in your view, is the worst human rights problem in the world today? After visiting over 80 countries as High Commissioner, I felt I could answer that question with a one-word response: poverty.

It was not the answer journalists expected. It may not be what all of you immediately think of as the biggest human rights challenge facing our world. But the reality is that poverty results in denial of the full range of rights for billions of people today, both economic and social rights - such as the right to a decent standard of living, to education, to adequate housing and access to food and water and to the highest attainable standard of health - but, equally, to civil and political rights - of voice, of participation in the life of the community, of protection against official abuse, all of which, if guaranteed can lead to significant improvements in realizing still other fundamental rights.

We all recognize today that attacking the roots of poverty is the only way to achieve sustainable progress in the state of health and human rights around the world. That requires a range of actions from better nutrition education for mothers to mass vaccination campaigns, from access to basic antibiotics to the provision of bed nets for malaria prevention and condom use programs to prevent the spread of HIV / AIDS and other sexually transmitted diseases. These are the relatively inexpensive and well-known interventions that can have measurable impacts on the health of people around the world.

Yet we know as well that today's global health picture⁴ is characterized by widening inequalities. Those of us fortunate enough to have been born in rich countries can hope to live into our seventies or eighties⁵. By contrast, the life expectancy of a child born today in Sub-Saharan Africa is age 46. This is largely a result of the HIV/AIDS epidemic, which is decimating the African continent, particularly Sub-Saharan Africa. The pandemic, which is no longer a death sentence in rich countries, killed approximately 2.3 million Africans in 2003⁶, most of them in the prime of their lives. 26.6 million men, women and children in the region have the virus. Over the next decade, AIDS could claim the lives of up to one-quarter of the adult population.

Yet in all of Sub-Saharan Africa, only 50,000 people - a tiny fraction, approximately 1% of the 4 million HIV/AIDS sufferers in need of treatment - are presently receiving anti-retroviral therapy. To add to the burden of AIDS, two "old" diseases - malaria and tuberculosis - are making a dramatic resurgence in poor countries. This is due to resistance to the relatively inexpensive and effective treatments which had been used in the past to treat them.

⁴ See WHO, 2003 World Health Report, "Shaping the Future", at www.who.int.whr

⁵ Id

⁶ UNAIDS, 2003

Sadly, this somber picture is by no means limited to AIDS, malaria or TB. In 2002, 10.5 million children under five years of age died worldwide. 98% lived in developing countries, and the vast majority of these deaths were from common diseases such as diarrhea and pneumonia. Maternal mortality, for its part, continues to claim the lives of more than half a million women a year, a number which masks shocking disparities among countries and, globally, has remained unchanged in the last 25 years. The fact is that most of these deaths - whether from HIV/AIDS, malaria, TB, childhood mortality or maternal mortality - are avoidable. The present situation is an affront to internationally agreed development and human rights commitments that have been made by the nations of the world.

The message I wish to convey to you today is that the governments of OECD countries have both the means and the collective responsibility to work with and encourage developing countries to do more to fight extreme poverty. A critical step in that direction would be by taking international health related commitments seriously.

But what are the precise obligations of assistance and cooperation for helping poor countries to face these major human rights challenges, particularly the right to the highest attainable standard of health, which is so central to human dignity and well-being? And to what extent is the international community taking seriously the commitments it has already made to the joint actions needed to realize fundamental rights for all people?

Let me try to shed some light on these questions from a rights perspective, first, by briefly "unpacking" what the right to the highest attainable standard of health, or "the right to health" to use the common short formulation, really means and how, if taken seriously, it would change the way we look at efforts to improve health and development.

I should point out that right to health obligations are found in numerous treaties that bind most OECD countries. They include: the Preamble of the Constitution of the World Health Organization; the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child, ratified by 192 countries.

The right to health, as elaborated in the International Covenant on Economic, Social and Cultural Rights, recognizes "the right of everyone to the highest attainable standard of physical and mental health" and outlines the steps to be taken by governments to realize such rights. Clearly, it is not to be understood as the right to be healthy. The right to health contains both freedoms and entitlements: "The freedoms include the right to control one's health and body, inclusive sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."⁷ As an inclusive right, the right to health is seen to extend "...not only to timely and appropriate health care but also to the underlying determinants of health, such as

Access to safe and potable water
Adequate sanitation
Adequate supply of safe food, nutrition and housing
Healthy occupational and environmental conditions,

7 ICESCR "General Comment" No.14 (2000) para 8.

Access to health-related education and information, including on sexual and reproductive health, as well as Participation in health related decision-making at the community, national, and international levels.”⁸

Today the right to health, or, in some cases, the more limited right to healthcare, is constitutionally recognized and protected in over 100 countries.

What is often not discussed, however, is that within the international framework, the right to health gives rise not only to domestic obligations of governments towards their own people, but also, crucially, to international obligations on the part of developed countries. These international obligations are set out in Article 2 of the Covenant. Member States undertake to take steps individually but also through “international assistance and cooperation”.

We have seen this commitment to international assistance take many forms. For example, in 1978, all WHO members solemnly affirmed their commitment towards “Health for All” by the year 2000 in the famous Alma Ata Declaration. Sadly, 25 or 26 years later, not only has the “health for all” commitment not been realized, but life expectancy has actually declined in a number of African countries, to levels unprecedented since the 1950s. In 14 African countries, current levels of childhood mortality are higher than they were in 1990.⁹

To be sure, there have been some global health successes, such as the eradication of smallpox. Hopefully, this enormous success will be repeated in the near future with the eradication of polio. But, notwithstanding these success stories, in the third world, people still die by the millions from treatable and preventable diseases. Why? There are many reasons such as medicines are too expensive, because there are no hospitals, because health systems have been decimated by decades of structural adjustment and/or poor governance and corruption, because doctors and nurses die of AIDS, or leave to work in rich country hospitals.

As most of you will know, the Millennium Development Goals or MDGs are the set of specific targets and commitments adopted at the start of this century in the UN Millennium Declaration of September 2000. These eight Goals, which were adopted with great fanfare by the largest gathering of Heads of State ever assembled, include halving the number of those in extreme poverty and hunger by 2015, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and, last but not least, Goal 8, developing a global partnership for development.

As we all know, globally, the world is on track to achieve Goal 1, thanks to a massive reduction in income poverty in China and India. But unfortunately, at the current rate, the WHO and the World Bank estimate that many developing countries are simply not on track to achieve their health related MDG objectives.

What is needed to turn the tide? What are the obstacles to reaching the health MDGs and what can be done, what must be done, by rich countries?

First and foremost, development experts agree that there is a need for a massive increase in ODA, starting with a serious commitment to funding the Global Fund for AIDS,

⁸ ICESCR “General Comment” No.14 (2000) para 11.

⁹ Id, at 8

Malaria and TB. In addition, I understand from conversations with my colleagues at UNAIDS, WHO, and at the UN Millennium Project, that the MDGs will not be met without a new focus, and new thinking, on health systems.

This is where human rights play a critical role. Increasing levels of ODA without attention to human rights, without attention to the values of equality, non-discrimination, empowerment and participation, will not benefit the poor, and will only lead to short term, unsustainable results. The World Bank¹⁰ has recently suggested that all donor assistance programs be coordinated around the PRSP programs, which reflect these values. Colleagues at the Millennium Project are focusing on the need to strengthen health systems, rather than concentrating on vertical interventions. In particular, more attention has to be paid to vulnerable populations, minorities, the rural poor, women especially. As the Health Minister of India has suggested, “aid donors have to concentrate less on quick wins in developing countries, and take their money and expertise into remote, rural areas where poor people need the most help with maternal and child health mortality issues.”¹¹

In the fight against HIV/AIDS, it is clear that attention to human rights and gender issues, at local, national and global levels, leads to better, more effective policies. This has been a major area of work for my new project, the Ethical Globalization Initiative. We have collaborated with the Steering Committee of the Global Coalition on Women and AIDS--of which I am proud to be a member—to develop specific recommendations for NGOs, governments, UN organizations and civil society groups working in the area of women, girls and HIV/AIDS.

The breadth of the Coalition’s policy work reflects the complex social, cultural and economic dimensions of gender discrimination and inequality: the recommendations focus especially on violence against women, women’s property and inheritance rights, girls’ education and equitable access to care and treatment.

We recently took these recommendations to a conference on gender and HIV/AIDS at the University of Pretoria, South Africa, which I co-chaired with Graça Machel, and which assembled community leaders and Parliamentarians from through out Southern Africa. Our goal was to act as a bridge, so to speak, between an international initiative such as the Global Coalition for Women and AIDS, and the grassroots level. Participants not only shared best practices, knowledge and experience, but, even more importantly, developed concrete action plans for implementation in their home countries. I would urge donor countries to take stock of such plans, which reflect international human rights principles but also local cultural traditions and conditions on the ground. We certainly need to reflect on how donor practices could better support these commitments.

There are other forms of international cooperation which are also important to stress as we move forward in efforts to link human rights, health and development. For example, I understand that Canada is the first country to pass legislation to facilitate exports of generic drugs to poor countries under the WTO decision of last August.¹² My friends at AIDSLAW Canada and MSF tell me that the new bill is not perfect, that it has some serious flaws. However, it shows political leadership, and I hope that other countries will soon follow in Canada’s footsteps to facilitate the export of desperately needed generic medicines to poor countries.

¹⁰ See WB/WH Issue Paper, “Resources, Aid Effectiveness and Harmonization, Issues for Discussion at High Level Forum on the Health MDGs”, December 2003

¹¹ WB Newsletter, January 9, 2004

¹² See www.aidslaw.ca for information on Bill C-9

Finally, I would like to mention a new Irish initiative, which I am exceedingly proud of, the Irish Forum for Global Health. It will be launched in Dublin this July, with an explicit focus on fulfilling the international obligations of Ireland under the internationally protected right to health.

Health has become a new international priority. With our resources, financial, technological and other, we are in a position to achieve our common dream of human dignity and health for all. What is needed now from OECD governments is political will to achieve internationally agreed commitments.

Thank you.