Check against delivery

Statement by Paul Hunt
Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

62nd session of the General Assembly
Third Committee
Item 70 (b)

25 October 2007
New York

President,
Distinguished Delegates,
Ladies and Gentleman,

Last year I reminded the General Assembly that over 500,000 women die in childbirth or from complications of pregnancy every year. Every minute - one death. 95% of those dying are either African or Asian.

Most of these maternal deaths are preventable.

The scale of maternal mortality dwarfs the number of 'disappearances' and death penalty cases. Yet 'disappearances' and death penalty cases attract much more attention from the human rights community than preventable maternal mortality. 'Disappearances', for example, have a UN human rights 'special procedure', as well as international and regional human rights treaties. And so they should. 'Disappearances' are an extremely serious human rights issue. But so is preventable maternal mortality with its impact upon women's rights to life, health, equality and non-discrimination. And yet there is not a single human rights mechanism with a focus on the immense problem of preventable maternal deaths.

Since I raised these issues with you last year, UNFPA, the European Union and the University of Essex have produced a publication which looks at maternal mortality through the right-to-health lens.[1]

Last week a major, high-level and successful global conference on maternal health took place in London. Human rights were one of the themes recurring - intermittently - during the conference.

The conference saw the launch of a new *International Initiative on Maternal Mortality and Human Rights*.[2] Thoraya Obaid, the Executive Director of UNFPA, Mary Robinson, former UN High Commissioner for Human Rights, and others, spoke at the launch.

Driven by civil society, this Initiative aims to highlight the human rights catastrophe of maternal mortality. It aims to use human rights to strengthen - to reinforce – the existing commendable efforts to reduce maternal mortality and to promote functioning health systems. It aims to encourage maternal health workers to use human rights analysis, advocacy and networks to further their goals.

The Initiative is a challenge to both developed and developing countries. When data in developed countries are disaggregated, they often reveal that maternal mortality among minorities and indigenous communities is significantly higher than among dominant groups. Also, developed countries have a human rights responsibility - reflected in Millennium Development Goals 5 and 8 – to take reasonable measures to address maternal mortality in developing countries.

I am pleased to report that the Government of India has invited me to undertake a formal mission in November to look at maternal mortality. This mission will enable me to explore,

---

[1] Paul Hunt and Judith Bueno de Mesquita, *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health*, UNFPA/EU/University of Essex, 2007.
[2] For information about the Initiative, contact mstoffregen@reprorights.org

in detail, the practical contribution that the right to health can make in our collective struggle against preventable maternal deaths.

Still, there is much more to be done to ensure that maternal mortality receives the human rights attention it deserves.

Here, the Human Rights Council can play a leadership role.

I recommend that the Council convenes a Special Session on maternal mortality. The key UN agencies could be invited to offer their insights and expertise. States could share their good practices.

This would be a unique opportunity for the Council to tell the world that preventable maternal mortality is a human rights issue of enormous gravity. Of course, human rights do not provide magic solutions to the global problem of maternal mortality. But human rights have a practical contribution to make. These are among the vital messages that a Special Session could convey.

Most importantly, a Special Session could save women's lives and reduce suffering.

Water and sanitation

The right to the highest attainable standard of health is more than a right to medical care. Additionally, it extends to the pre-conditions of health, also known as the underlying determinants of health.[3] There are many underlying determinants of health, including access to safe water, adequate sanitation, an adequate supply of safe food and nutrition, freedom from discrimination, to name but a few.

Unfortunately, there is a definite tendency among some Governments and international organisations to devote a disproportionate amount of attention and resources to medical care, at the expense of the underlying determinants of health. This is deeply regrettable because both are fundamental, inter-related elements of the right to the highest attainable standard of health.

My present report to the General Assembly focuses on two underlying determinants of health: access to safe water and adequate sanitation.[4]

Access to improved water and sanitation would save millions of lives and reduce terrible suffering. It would reduce malaria, diarrhoeal diseases, including cholera, blindness from trachoma, and so on. It would also bring substantial economic benefits. According to WHO, each dollar invested would yield an economic return of between $3 and $34, depending upon the region.

My report analyses water and sanitation through the prism of the right to the highest attainable standard of health. I will not repeat that analysis here but emphasise the inadequacy of many States' water and sanitation policies, programmes and laws.

---

[3] See, for example, article 12 International Covenant on Economic, Social and Cultural Rights and article 24 Convention on the Rights of the Child.

[4] Chapters IV and V.

States should recognise that the right to the highest attainable standard of health includes access to safe water and adequate sanitation. Measures to enhance access to safe water and sanitation must give particular attention to disadvantaged groups and individuals. It is extremely important that water and sanitation policies are gender-sensitive. Large-scale public awareness health campaigns are needed to provide information on hygiene and safe water storage. Many States have yet to put in place effective monitoring and accountability mechanisms in relation to water and sanitation.

Global warming is a serious obstacle to the right to the highest attainable standard of health. It has led to a decline in dependable access to water, as well as disruption to natural ecosystems. Warmer and wetter conditions are increasing the range of mosquitoes, tsetse flies and other vectors which spread tropical diseases like malaria and yellow fever. As clean water sources evaporate, people resort to polluted alternatives that lead to ill-health. People living in poverty are disproportionately affected by the adverse effects of global warming. The international community has a duty to recognise and confront the health threats posed by global warming.

I recommend that the Human Rights Council undertake, as soon as possible, a study that looks at the impact of climate change on human rights, including the right to the highest attainable standard of health.

Impact assessments

A human rights impact assessment is a process for predicting the likely impact of a proposed policy, or other initiative, on the enjoyment of human rights. If the assessment finds that the human rights impact is likely to be negative, the Government then has an opportunity to revise and improve the proposed policy before it is finalised and implemented.[5]

Without an appropriate impact assessment methodology, a Government cannot know whether its proposed initiatives are on target to progressively realise the right to the highest attainable standard of health, as required by international human rights law.

From the right to health perspective, an impact assessment methodology is a key feature of a health system.

In 2006, I co-authored a report on impact assessments and the right to the highest attainable standard of health.[6] I am very grateful to UNESCO for funding this research. This co-authored study introduces a human rights impact assessment methodology, with a particular focus on the right to the highest attainable standard of health.

The study is outlined in my present report to the General Assembly.[7]

Neglected diseases

---

[5] In my first report to the Commission on Human Rights, I signalled my intention to look at the issue of impact assessments. The Commission responded by passing a resolution expressly encouraging me to pursue this analysis.

[6] My co-author is Gillian MacNaughton, to whom I am most grateful. *Impact assessments, poverty and human rights: A case study using the right to the highest attainable standard of health*, UNESCO, 2006. The report is available from the website of Essex University, Human Rights Centre, Right to Health Unit www2.essex.ac.uk/human_rights_centre/rth/projects.shtm

[7] See Chapter III.

In my first report to the Commission on Human Rights, I signalled my intention to look at the issue of neglected diseases. The Commission responded by passing a resolution expressly encouraging me to pursue this analysis.

By neglected diseases I mean those diseases mainly afflicting the poorest people in the poorest countries, such as river blindness, sleeping sickness and lymphatic filariasis. According to WHO, almost 1 billion people suffer from severe and permanent disabilities and deformities arising from neglected diseases.

The introduction of basic public health measures, such as access to clean water and sanitation, would significantly reduce the burden of several neglected diseases. Where medical interventions exist, they generally fail to reach those populations in greatest need. History shows that the development of new drugs and vaccines for neglected diseases has been under-funded, largely because there has been little or no market incentive. In the last few years, however, some pharmaceutical companies deserve credit for taking active steps to redress this historic neglect and imbalance.

In 2006, I undertook a formal mission, in cooperation with WHO, to Uganda and my report looked exclusively at neglected diseases. Although the report focuses on Uganda, much of its analysis and many of its recommendations have application to the many States whose people suffer from neglected diseases.[8]

I am pleased to report that a few weeks ago a study was published called *Neglected Diseases: A Human Rights Analysis* which I co-authored with three colleagues.[9] The report was published by the Special Programme for Research and Training in Tropical Diseases (known as 'TDR'), which is sponsored by WHO, UNICEF, UNDP and the World Bank. TDR also provided financial support for the necessary research -- I am most grateful to TDR for its extraordinary support. I am also very grateful to OHCHR and WHO for their contributions to this project.

When read together, the TDR publication and the Ugandan report provide a practical introduction to neglected diseases and human rights. Together they show that the right to the highest attainable standard of health is not mere rhetoric, but a practical tool that can contribute to good policy making.

Draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines

Last year, my report to the General Assembly included a chapter on the human right to medicines. States have primary responsibility for enhancing access to medicines and so most of my report looked at States' duties. But the report also looked at the responsibilities of pharmaceutical companies in relation to access to medicines.

The report identified some major questions. What, precisely, are the human rights responsibilities of pharmaceutical companies in relation to access to medicines? How can we expect pharmaceutical companies to respect human rights if it is not clear what is required of them?

---

[8] In 2007, I undertook a follow-up mission to Uganda. In 2004, I undertook a formal mission to the World Trade Organisation, neglected diseases being one of the issues my report focused on.

[9] My co-authors are Rebecca Steward, Judith Bueno de Mesquita and Lisa Oldring, to whom I am most grateful. *Neglected diseases: A human rights analysis*, TDR, 2007.

The report explained that I had embarked on a process of preparing draft Guidelines for pharmaceutical companies in relation to access to medicines; the draft was an attempt to respond to these major questions. Last year, in the interactive dialogue with the Third Committee, I was encouraged to proceed with this challenging project.

I am pleased to report that I have now prepared, for consultation, *draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines*.[10] The draft was made available for public comment in mid-September 2007, following a multi-stakeholder workshop at the University of Toronto. Pharmaceutical companies participated at this workshop.

The draft is available for comment until 31 December 2007. I am now actively canvassing the comments of various stakeholders, including pharmaceutical companies. Next month, for example, I will discuss the draft with the International Federation of Pharmaceutical Manufacturers and Associations. I will also be meeting some pharmaceutical companies on a bilateral basis.

The draft Guidelines address some key access-to-medicines issues, such as research and development for neglected diseases, pricing, ethical marketing, clinical trials, and corruption.

A commentary makes the link between the selected issues and the right to the highest attainable standard of health. Then forty-eight draft guidelines are put on the table for comment.

May I emphasise that the draft does not proceed on the basis that pharmaceutical companies are legally bound by international human rights law. Nor does the draft use the peremptory word "must". Rather, it uses the much more modest language "should". In other words, I have deliberately avoided the most controversial doctrinal issues that have plagued debates about business corporations and human rights for many years.

Instead, I have tried to be practical and constructive, and sought to apply the right to the highest attainable standard of health to the very specific domain of pharmaceutical companies and access to medicines.

Since my appointment in 2002, I have met with pharmaceutical companies on numerous occasions and have closely discussed with them the issues that form the core of the draft Guidelines. These discussions have been extremely helpful and they have profoundly influenced my draft. Some of these discussions have been in the form of day-long consultations organised by Realizing Rights: The Ethical Globalization Initiative, led by Mary Robinson. Others have been during visits to pharmaceutical companies.

In a series of substantive meetings with a number of major pharmaceutical companies, Mrs Robinson and I put forward a two-phase proposal. The proposal was discussed at length with the companies and revised to accommodate a number of their concerns.

---

[10] The draft Guidelines are available from the website of Essex University, Human Rights Centre, Right to Health Unit www2.essex.ac.uk/human_rights_centre/rth/projects.shtm

First, we suggested that a small group of human rights experts, and representatives from pharmaceutical companies, work together to identify as much common ground as possible, as well as good faith disagreements, in relation to access to medicines. We envisaged this would take two years and would generate an important, useful report that began to clarify what can properly be asked of pharmaceutical companies in relation to access to medicines and human rights.

Second, a small group of experts would then be appointed, by consensus among those participating in the initiative, to use this report to evaluate the policies and practices of certain pharmaceutical companies. These evaluations would be made public. We envisaged this second phase would last for an initial period of three years.

The hallmark of our two-phase, five-year proposal was constructive cooperation and collaboration with a number of major pharmaceutical companies.

To their considerable credit, two companies, Novartis and NovoNordisk, were willing to proceed with the proposal. Unfortunately, however, the majority of companies involved in the initiative were not willing to go-ahead. Reluctantly, Mrs Robinson and I decided that buy-in from only two companies was insufficient for what was designed to be a collaborative initiative engaging a range of major pharmaceutical companies. Accordingly, we felt we had no alternative but to put the proposal aside.

But the work still needs to be done.

I hope the Guidelines - after extensive consultations - will clarify what can reasonably be expected of pharmaceutical companies in relation to access to medicines and the right to the highest attainable standard of health.

Of course, I have sole responsibility for the draft Guidelines and will have sole responsibility for the final version.

May I again emphasise that States have primary responsibility for enhancing access to medicines. So far, in my access-to-medicines work, I have given priority to consideration of this State responsibility. My 2006 report to the General Assembly includes a detailed chapter setting out these State duties. Over the last five years, when on country mission, I have held States to account in relation to their right to health duties and access to medicines. Drawing on this experience - and if my resources permit – I hope to prepare, in collaboration with treaty-body and other experts, some draft Guidelines for States in relation to access to medicines.

Now, however, it is time to look more closely at the human rights duties of pharmaceutical companies in relation to access to medicines.

Regarding the draft Guidelines for pharmaceutical companies, all comments will be most welcome before the end of this year.

My aim is to finalise these Guidelines in 2008.