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Statement by Mr Anand Grover

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14th session of the Human Rights Council

Agenda Item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

3 June 2010
Geneva

Mr President
Distinguished Delegates
Ladies and Gentlemen,

Since I last reported to the council in June last year, I have undertaken a number of activities to further develop the mandate, and raise awareness of the right to health globally.

As well as undertaking country missions to Poland and to Australia in May and November 2009, respectively, and Guatemala in May this year , I have participated in a number of consultations and conferences on the right to health – I will not mention them now, but some of the most important events are listed in my statement.

In September 2009, a consultation was organized in Kathmandu, Nepal, which brought together 53 representatives of civil society organizations from all countries in the South Asian Association for Regional Cooperation (SAARC) region. This provided an opportunity for information exchange regarding the right to health in South Asia, and to inform the concerned communities about the mandate's scope and methodology. A similar consultation was held in Guatemala, in March 2010, bringing together civil society organizations from across Central America. This consultation also provided an excellent opportunity to gain information, which proved essential to completing the country mission in Guatemala in May.

In addition to these consultations, I participated in the International Conference on AIDS in Asia and the Pacific in August 2009, a Parliamentarians' consultation on maternal health in the Asia-Pacific region in Bali, and a civil society consultation on migrant workers and health organized by CARAM Asia in Kuala Lumpur in late October 2009. I gave keynote presentations at the Global Partners in Action NGO Forum for the review of ICPD@15 in Berlin, City University New York, Columbia University and Yale University, the Stakeholders' meeting of the Human Rights Development Initiative in Johannesburg in October 2009, and the International Conference on Realising the Rights to Health and Development for All in Vietnam in October 2009. I also gave lectures during a course on the Justiciability on Economic, Social and Cultural Rights at the Institute for Human Rights Abo Akademi University, Turku/Åbo, Finland, in November 2009, and the 'Judiciary and the Right to Health Conference' held in Princeton in March 2010.

In February 2010, I travelled to Afghanistan at the invitation of Save the Children, to consult with civil society groups regarding the realization of the right to health in Afghanistan, with a particular focus on paediatric and maternal health. The visit involved a meeting with ACBAR, the Agency Coordinating Body for Afghan Relief, as well as a consultation with Afghani children on barriers surrounding realization to their right to health.

My present report to the Human Rights Council focuses on criminalization of consensual sexual behaviour, and its impact on the enjoyment of the right to health; specifically, criminalization of same-sex conduct and sexual orientation, sex work and HIV transmission.

I consider criminalization of consensual, same-sex conduct between adults, along with criminalization based upon sexual orientation or gender identity, to infringe the enjoyment of the right to health both directly and indirectly. The concepts of privacy and equality have been recognized in domestic jurisdictions internationally as being central in protecting the rights of affected individuals, including the right to health.

Criminalization of sex work and surrounding practices, such as solicitation, also create barriers to access healthcare services, facilities and goods, resulting in poor health outcomes and infringements of the right to health. Lack of legal recognition of the sector results in unsafe working conditions, particularly because sex workers do not have recourse to legal remedies for occupational health and safety issues. I also considered the distinction between sex work and trafficking, and note that legislation and interventions that do not distinguish but instead conflate these groups increasingly infringe sex workers' enjoyment of the right to health. There also is need to recognize that groups of sex workers that voluntarily enter the sector have been instrumental in preventing trafficking of individuals in that sector.

Apart from failing to meet the objectives of criminal law, criminalization encourages violence, abuse and stigmatization, and impairs upon the dignity of individuals and infringes the enjoyment of the right to the health of same-sex communities.

I also considered the impact of criminal laws on HIV transmission. This includes laws directly addressing HIV transmission, as well as the application of general criminal laws to HIV transmission or exposure. I note that these laws have failed to achieve legitimate public health aims or the objectives of the criminal law, and are incompatible with a right to health approach. Where unintentional transmission is criminalized, these laws undermine public health efforts. Although intentional, malicious HIV transmission can be legitimately criminalized, I contend that specific criminal laws concerning HIV transmission are generally unnecessary in achieving their objective or fulfilling of the right to health. It has also been noted that criminalizing HIV transmission targets existing minorities and vulnerable groups, including women, and further stigmatizes them.

Ultimately, decriminalization is only one necessary response to each of these issues, alongside other measures necessary as part of a comprehensive right to health approach. Where decriminalization has been adopted, it is noted to have positive health outcomes. These include human rights education, participation and inclusion of vulnerable groups, efforts to reduce stigma and discrimination, and appropriate health regulations in respect of these groups.

Mr President,

In May 2009, I accepted the invitation of the Government of Poland to visit the country, with a view to understand how the right to health has been implemented, including the measures taken for its successful realization and the obstacles encountered. The specific focus of this mission was on the right to sexual and reproductive health, HIV and harm reduction, drug

dependence treatments and relevant laws, policies and practices, and their impact on the enjoyment of the right to health.

I commend the establishment of a number of initiatives by the Polish Government; notably, enactment of legislation concerning Patient's Rights, and the office of the Patient's Rights Ombudsman.

Although the health system in Poland is widely funded, through development of the National Health Fund, and services are generally accessible on the basis of non-discrimination and equality, I am concerned that budgetary allocation is insufficient to meet the increasing needs of Poland's population.

Rights to sexual and reproductive health remain an issue of concern to me; particularly, access to legal abortions, contraception and prenatal testing, and the role of non-state actors in impeding access to health services. I note with concern that the concluding observations of the Committee on Economic, Social and Cultural and the directions of the European Court of Human Rights in Tysiac's case remain to be implemented.

Access to safe abortion services must be ensured through establishment of protocols in health care services, including in relation to conscientious objection. I note the increased efforts on the part of the government to ensure access to sexuality education and information, although further steps in this regard would be encouraged.

The prevention and treatment of HIV is also a concern in Poland, largely due to insufficient implementation of harm reduction policies in relation to injecting drug use. These include clean needle and syringe distribution, outreach and peer education, condom promotion and opioid substitution therapy. The Special Rapporteur commends the decision of the local Gdansk authorities to initiate the methadone maintenance program by September 2009, but regrets to note that the program is not yet established. However, Polish law currently allows for penalization of possession of methadone.

As there has been a growth in HIV infections of late, there is a need to expand treatment programs and ensure sufficient information regarding the epidemic is disseminated to the population. Although the Government has displayed its commitment to treatment of HIV, through access to ARVs, more needs to be done in respect of prevention of HIV.

In November of 2009, I visited Australia to examine how the right to health has been implemented, focusing particularly on the status of indigenous health and detainee health, both in prisons and immigration detention.

Currently, Australia's Constitution and legislation contain no recognition of the right to health, as recognised in various instruments to which Australia is a signatory. I urge the Government to take necessary steps to incorporate international human rights standards into domestic legislation, all of which should be justiciable, including economic, social and cultural rights. This would provide an effective remedy to all whose rights may have been violated.

Although Australia has a strong national health system, which gives the majority of the population access to quality services, there is a major gap in service provision between 'mainstream' Australia and the indigenous population. Positive steps have been taken to

redress this, including significant increases in funding to the sector and targeted interventions.

However, the historical context of colonization, along with years of neglect, have led to a situation where poor socio-economic conditions impact detrimentally on the social determinants of health, and it is integral to address these in order to realise the right to health of all Aboriginal and Torres Strait Islander people. These include educational attainment, housing, employment, access to basic amenities, and health workforce and political participation by indigenous people.

The precarious situation of the Aboriginal and Torres Strait Islander people was highlighted by the implementation of the Northern Territory Emergency Response, which introduced a number of measures impacting on the health of indigenous people initially without consultation or participation. To this end, the operation of the *Racial Discrimination Act* (Cth) was suspended in the Territory, which is deeply concerning. Though a review of this response has taken place, including consultations with affected communities, a number of issues remain outstanding.

The healthcare situation in detention centres, including prisons and immigration detention facilities, are generally of a good standard. However, more efforts need to be made to ensure that primary health care services are uniformly available and are of good quality. I am concerned about the disproportionate rate of detention of indigenous persons, and the disparity of conditions in the prisons in which they are generally detained. There is also a paucity of resources dedicated to harm reduction in prisons, which needs to be addressed.

I am also concerned about the Australian Government's continuing policy of mandatory immigration detention, particularly in light of the impact detention has on mental health of detainees, including those that have previously experienced torture and trauma. Although health care services in these facilities are of a good standard, more efforts need to be made to ensure access to interpreters and other services.

Mr President,

In this session, I also present the mission report to India of the previous mandate holder, Mr Paul Hunt. His mission looked at maternal mortality, focusing on two states: Maharashtra and Rajasthan.

The Indian authorities deserve credit for putting in place a number of very important, ambitious and progressive health initiatives, such as the National Rural Health Mission, Janani Suraksha Yojana and Chiranjeevi Yojana. Moreover, there is evidence that the rate of maternal mortality in India is declining. Indeed, since the mission report was finalized, new data confirm that India is making progress in relation to maternal mortality.

However, even taking into account the latest data, the rate of maternal mortality remains extremely high for a middle-income country of India's stature and level of development. At the present rate, India will not reach its MDG5 targets.

The mission report takes a selection of India's maternal health initiatives and examines them through the lens of the right-to-health approach, specifically in its application to maternal mortality. The report identifies a number of vital shortcomings; for example, there are

insufficient numbers of skilled birth attendants, as well as new trainees in the sector, and there is inequitable access to such healthcare workers. Additionally, the report highlights the lack of systems to accurately monitor and review maternal mortality. May I take this opportunity to urge all countries to give careful attention to the right-to-health approach to maternal mortality that is clearly set out in a Supplementary Note to this report and is available online.

While the mission report focuses on India, it uses a right-to-health approach to maternal mortality that is an extremely useful, practical tool for all countries: low-income, middle-income and high-income.

Mr President, I would like to turn now to the priority areas that I have identified for 2010 and 2011.

Less than a month ago, I visited Guatemala and I would like to thank the Government for inviting me and arranging a rich and interesting programme. I commend the Government for their openness and readiness to discuss a wide range of issues that have been raised during the mission. I will submit the report to the Council at the June session next year.

Until my next report to the Council, I intend to continue my current program of regional consultations, in order to further disseminate information regarding the right to health, gain information from civil society groups and popularize the mechanism for complaints. I shall be conducting consultations in East Africa and Eastern Europe in the latter half of 2010. I also hope to complete a mission in the Middle East during that time, with a view to conducting a consultation in this area in 2011.

I shall also be attending a number of conferences concerning the right to health, including the annual HIV/AIDS conference in Vienna in July. I am looking to use these opportunities to raise the visibility of the mandate and to encourage the use of the existing complaints mechanism in order to ensure and improve the enjoyment of the right to health of all.

I welcome the comments of Member States on any aspect of my report and on my mandate in general.