WHO Assistant Director-General speaks to importance of making human rights a reality

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• Firstly, I would like to express my special thanks to Sir Nigel Rodley and Lorna MacGregor, Chair and Director of the Essex Human Rights Centre, and to congratulate Essex University on its milestone anniversary. I am delighted that the University is taking this opportunity to celebrate the pioneering and unique contribution of its Human Rights Centre.

• The Centre is well-known as a global leader in the theory and practice of human rights, and first gained global prominence for its work on civil and political rights, including litigation before the European Court of Human Rights. The numerous cases successfully conducted by Professor Francoise Hampson, and the late Professor Kevin Boyle, helped to shape the jurisprudence of Strasbourg. Professor Sir Nigel Rodley’s ground-breaking work as UN Special Rapporteur against torture, and his leadership within the UN Human Rights Committee, has also ensured the pre-eminence of the Centre.

• However, I am delighted that while retaining a focus on civil and political rights, the Centre’s work also focuses on economic, social and cultural rights. To this end, WHO and the Centre have been working closely in recent years on the right to health and health care, and to do what the Centre does best, which is to bring together academic research with technical practice and reality.

• Our collaboration with Professor Paul Hunt, Dr Linsey McGoey and others associated with the Human Rights Centre goes back many years, from our earliest collaboration when as a member of the UN Committee on Economic, Social and Cultural Rights, Paul helped draft General Comment 14 on the right to health, collaborating very closely, if discreetly, with WHO staff.
during this drafting process. Then throughout his tenure as Special Rapporteur for the right to health, and beyond, in the last 5-6 years since he stepped down as Rapporteur.

- I would also here like to acknowledge the Centres’ well known network of alumni, some of whom are here tonight. I have been told that this network is informally known as the ‘Essex mafia’...and, being from Italy – am not so comfortable with this label! Still, at WHO, we have the pleasure to have on our staff experts who were trained in human rights at Essex and I hope that, as the years pass, there will be more.

- WHO has made the promotion and fulfilment of the right to health a founding principle of its Constitution, and member states have, over the years, re-asserted this commitment through various Resolutions and decisions, both in Geneva, and in our regional offices, on issues as varied as mental health, the environment, violence against women, non-communicable diseases and the cause that is closest to my heart, women and children’s health.

- But while the commitments are there, the sad truth is that we have struggled to translate these commitments into meaningful reality and tangible change in health of all people, everywhere, equally, without discrimination, and without making access to healthcare a cause of significant impoverishment.

- Looking to my co-panellists, while I have to recognise that the themes of our interventions may be very different, what we share is the gap between law, policy and practice that we see in our work.

- As we are all-too aware, in spite of all the laudable commitments, international frameworks and humble words, human rights continue to be flouted or marginalized, with the result that in many parts of the world, women are dying in childbirth from causes that are entirely preventable. Some 6.3 million children under five die each year, nearly half of which are a result of malnutrition. Adolescents who are unable to access safe sexual and reproductive
health services, has meant that complications linked to pregnancy and childbirth are the second cause of death for 15-19-year-old girls globally.

- The need for operationalization then stems from the need to bridge our commitment with action, to make the principle, practical. For us in the world of health, we are accustomed to the practical. Doctors are well known for their practical, and pragmatic ways, (perhaps the same cannot be said of lawyers!), and this demand for practicalities has been the driving force behind much of our work.

- In his book, Professor Michael Freeman, (another prominent human rights scholar at Essex University) writes that “to a considerable extent, the practice of human rights has been dominated by lawyers”. While recognising that “the cause of human rights owes a great deal to them”, he argues that if human rights are to gain more support - if they are to be put into practice – they require an inter-disciplinary approach.

- As ADG, WHO, and as a medical doctor and a health policy maker, I have to say that I cannot agree more forcefully with Professor Freeman.

- Lawyers have a vital role to play in relation to health-rights. But if human rights are to be operationalised in the health sector, it is imperative that health professionals and health policy makers, human rights experts and many others sit down together and figure out -- collaboratively, respectfully, humbly -- how health-rights shape health policies, programmes and interventions.

- This means each of us has to move out of our comfort-zone.

- For example, the lawyers have to be willing to move beyond health-related treaty provisions, general comments and judicial decisions. And health professionals have to be willing to recognise, for example, that monitoring is not the same as accountability, and that some sensible form of independent review of the health sector is exceedingly important.
• At WHO, we have found it useful to focus on three elements in order to ‘operationalize’ human rights. Partnership, accountability and impact. These 3 features underlie all of our efforts to translate rights into reality.

Partnership

• Within the cluster that I lead, partnership has become a byword for everything we do, and a principle we promote and demand of those we serve. Since 2010, we have partnered with the Office of the High Commissioner for Human Rights, the Partnership for Maternal, Newborn and Child Health (PMNCH), UNICEF and UNFPA to develop Technical guidance on a Human Rights-based Approach to Maternal and Under-5 Mortality and Morbidity, an undertaking requested of us by the Human Rights Council, following that body’s historic adoption of a Resolution on Preventable Maternal Mortality and Morbidity and Human Rights in 2009.

• This partnership hinges on a common objective, and recognition that this objective will not be met if we do not look at the problem through a lens of human rights, recognising the underlying determinants of ill-health and barriers to access.

• Nor we will reach that goal if we not apply solutions that will further the realisation of those rights, such as the right to informed consent, to comprehensive sexuality education, to facilities, goods, and services that are accessible, available, acceptable and of good quality. Underlying all this, we must ensure adequate budget allocations commensurate to needs that will address inequities in coverage.

• Our commitment to broad and multisectoral partnerships has also helped broker new ground in the development of a Global Strategy for Women and Children's Health to end preventable deaths of women, children, and adolescents by 2030 and to improve their overall health and well-being. This strategy, adopted in 2010, has explicit human rights content, and is currently being renewed in consultation with over 1,700 organizations at national, regional and global level.
- Working in partnership, we are drawing on the best available crowd-sourcing technology we have available, to ensure the voices and needs of the underserved are heard, and reflected. Which brings me to the second feature of our work, accountability.

**Accountability**

- Professor Asbjorn Eide, one of the co-authors of the Monograph, (about which I will speak a little later), recognised that one of the unique features of the Global Strategy for Women’s and Children’s Health lies in the way it makes accountability a cornerstone.

- Indeed, the Strategy has put in place clear standards and robust monitoring and reporting mechanisms to ensure accountability for results, to ensure that we reach the most in need.

- The Commission on Information and Accountability for Women and Children’s proposed a framework to track pledged resources and health expenditures for women and children, and called for a time-limited Independent Expert Review Group to report regularly to the UN Secretary General on progress. Secretary-General Ban Ki-Moon accepted this recommendation and the Independent Expert Review Group has submitted three annual reports to him -- in each report, explicit human rights considerations are prominent.

- In addition, we are working to strengthen Civil Registration and Vital Statistics as a key component of this work. Every year, the births of tens of millions of children go unregistered, and it is estimated that two-thirds of deaths are never recorded. Yet we have the technology to do better. If children are not registered, none of their rights can be fulfilled: health, education, civil and political rights all rely on the state recognition of the individual’s existence.
Impact

- Finally, we have been focusing our efforts on impact, because what matters is that people have access to, and can enjoy the benefits of good health and wellbeing, but also because nothing speaks to decision-makers and policy designers like cold, hard facts.

- To this end, we have been working hard to develop programmes and methodologies to gather more and better evidence of impact of human rights approaches. And the evidence is compelling.

- What we see, time and again, is that when those people most affected by ill-health and the causes of it are involved in planning and decision making, the programmes designed to prevent and treat them are more effective.

- Adolescents who are confident that they can seek appropriate information, counselling and care, without discrimination are more likely to use and adhere to health services and treatments.

- Patients who experience discriminatory behaviour, treatment and care on the other hand, or whose dignity is denied and whose rights are violated are unlikely to return.

- Rural, lower educated, impoverished, indigenous populations, people with disabilities, who face powerful and harmful gender norms, as well as all those whose specific characteristics and needs are not recognised or understood, continue to face undue hardship in accessing and enjoying their right to health.

- To human rights advocates, these realities seem obvious. Failing to address them seems fundamentally at odds with a right to health, and a contradiction of the commitments we have made as a global community. Yet, policy makers are faced with hard choices and multiple and competing demands. It is our task to do more and better to bridge this gap between principle and practice.
If there is evidence that human rights contribute to health gains, this supplements the legal and political reasons for respecting human rights. Of course, if there is no evidence, the legal obligation to respect human rights remains firmly in place.

Recognising this, WHO in 2011 began work on a Monograph, to document ‘Evidence of impact’, in close collaboration with former Special Rapporteur for the Right to Health, Paul Hunt. The Monograph drew on country experiences in Nepal, Malawi, Brazil and Italy, to assess the extent to which the explicit adoption of human rights had contributed to health gains in those countries.

In Nepal - a country recognised for its progress in drastically reducing maternal and under-5 mortality - the study team reported a growing and increasingly explicit adoption of human rights into laws, and policies, including the national Constitution, and the subsequent translation of this commitment into key programme areas in health. This explicit linkage allowed the authors to identify marked improvements in availability and accessibility of services – including improved access to emergency obstetric care, increases in uptake of maternal health services, and higher numbers of babies being delivered safely in hospital environments. Of course, in Nepal, there remains a long way to go in human rights and health.

Although these findings were encouraging, they have underscored the need for further work, and greater mobilization around this agenda, including further research and evaluation.

Since the Monograph was commissioned, WHO has also renewed its commitment to mainstreaming human rights, as part of a combined strategy to ensure gender, equity and human rights are built into our work across the organization.

In recent months, I have been invited to be guest editor for the Special edition of the Harvard-based Health and Human Rights Journal, that will focus on the evidence of impact of human rights on health. We have come a long way since Jonathan Mann, former WHO staff member, and founding father of that journal, first defined the synergies between health and human rights. As the resounding demand for ‘further’ guidance on the operationalization of human
rights, shows, and as the direction of current discussions on the ‘new’ sustainable development agenda suggests, there is likely to be a growing demand for that evidence in the years to come.

- But besides additional research, I believe it will be important to create a platform where Ministers and Secretaries of Health can discuss their success and challenges in relation to the operationalization of health-related rights.

- Bringing together communities of human rights law and health practitioners is already in our plans and is also a suggestion to create a time-bound Commission on Health and Human Rights of women and children, to further advance this work. We are now exploring this idea with our partners.

- We must be up to the job, we must find new pathways for the operationalization of human rights, especially the right to health. In conclusion, I thank the panellists and the Essex Centre, and look forward to the discussions.