

Interpreting the International Right to Health in a Human Rights-Based Approach to Health

PAUL HUNT

Abstract

This article tracks the shifting place of the international right to health, and human rights-based approaches to health, in the scholarly literature and United Nations (UN). From 1993 to 1994, the focus began to move from the right to health toward human rights-based approaches to health, including human rights guidance adopted by UN agencies in relation to specific health issues. There is a compelling case for a human rights-based approach to health, but it runs the risk of playing down the right to health, as evidenced by an examination of some UN human rights guidance. The right to health has important and distinctive qualities that are not provided by other rights—consequently, playing down the right to health can diminish rights-based approaches to health, as well as the right to health itself. Because general comments, the reports of UN Special Rapporteurs, and UN agencies' guidance are exercises in interpretation, I discuss methods of legal interpretation. I suggest that the International Covenant on Economic, Social and Cultural Rights permits distinctive interpretative methods within the boundaries established by the Vienna Convention on the Law of Treaties. I call for the right to health to be placed explicitly at the center of a rights-based approach and interpreted in accordance with public international law and international human rights law.

PAUL HUNT is Professor at the Law Department and Human Rights Centre, University of Essex, United Kingdom.

Please address correspondence to Paul Hunt, Law Department, University of Essex, Wivenhoe Park, Essex, United Kingdom, CO4 3SQ.
Email: phmhunt@essex.ac.uk.

Competing interests: None declared.

Copyright © 2016 Hunt. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

Among the dynamics that have shaped the recent development of the international right to health are a drive toward its “real-life” implementation for the benefit of individuals, communities, and populations, and a movement from short, general, abstract, legal treaty provisions toward specific, practical human rights guidance. These two trends are closely interrelated.

For example, the general comments of United Nations (UN) human rights treaty bodies have added flesh to the bare bones of human rights treaty provisions. Since 2002, UN Special Rapporteurs on the right to health have endeavored to apply the treaties and general comments to many themes, states, and other duty-bearers. When rapporteurs have encountered specific issues on which the existing jurisprudence gives no or scant guidance, they have offered their interpretations of the international right to health. UN agencies have adopted increasingly detailed guidance on how to operationalize human rights, for example, in relation to HIV/AIDS, tuberculosis, maternal mortality, under-five mortality, contraceptive information and services, and clinical management of female genital mutilation.¹ This has required agencies to interpret and apply treaties, general comments, and other jurisprudence, sometimes weighing the available evidence as part of their interpretative process. None of these initiatives is above criticism but, at least, as John Harrington and Maria Stuttaford put it, a “beginning has been made” to provide treaty provisions with detailed normative and operational content.²

Although very welcome, these important developments give rise to numerous complex issues. Alicia Yamin and Rebecca Cantor identify some of the formidable challenges, dilemmas, and contradictions generated by attempts to operationalize human-rights based approaches to health. For example, human rights are understood “as universal, deontological principles”—yet, in operationalizing them through rights-based approaches, “trade-offs and deeply contextualized political realities necessarily enter the equation.”³

This article aims to supplement Yamin and Cantor’s analysis by addressing two questions that

bear closely on contemporary discussions about health and human rights. First, what is the role of the right to health in human rights-based approaches to health? Second, since general comments, rapporteurs’ reports, and agencies’ guidance are exercises in legal interpretation, what is the legal methodology for the interpretation of the international right to health?

Although there is not yet a universally agreed definition of a rights-based approach to health, a good starting point is the account provided by the World Health Organization (WHO) and Office of the United Nations High Commissioner for Human Rights (OHCHR).⁴ This definition is considered by Flavia Bustreo, Paul Hunt, Sofia Gruskin, and others in *Women’s and Children’s Health: Evidence of Impact of Human Rights*.⁵ However, for the purposes of the present discussion, it is not necessary to favor one definition of a human rights-based approach to health. The important point here is that all these definitions encompass all relevant human rights, including the rights to life, information, privacy, participation, association, equality, non-discrimination, and the prohibition of torture and inhuman and degrading treatment. One of the key aims of this article is to explore the place of the international right to health in human rights-based approaches to health.

However, it is important to emphasize that there is merit in applying a rights-based approach to health rather than confining the analytical and operational “lens” to the right to health. Although the right to health is extensive, it is narrower than a human rights-based approach, and the wider “lens” may help devise a more comprehensive and effective strategy. Deploying several human rights may strengthen the human rights case by, for example, securing protection from a wider range of national and international laws and also by generating support from a broader coalition of groups and interests. Also, some duty-bearers still harbor ideological or other objections to the right to health, and they may be quicker to accept the relevance of civil and political rights, such as the right to life. Indeed, it might be possible to “smuggle” the right to health into a rights-based approach without trig-

gering ideological objections, although this article does not favor such a tactic. It is accepted that there will sometimes be advantages in adopting a human rights-based approach rather than relying only on the right to health.

The problem identified and addressed in this article is that rights-based approaches to health, however they are defined, run the risk of playing down, and sometimes obscuring, the central role of the international right to health. For example, when I served as UN Special Rapporteur on the right to health and, more recently, when I participated in a statutory human rights inquiry into Northern Ireland's emergency health care, it was sometimes suggested by those in authority that they were *implicitly* including the right to health in policy-making or a rights-based approach to health. This is problematic because, in such a situation, only they know whether the right to health is present and, if it is, how it is interpreted and applied. Such arbitrariness is inconsistent with the *raison d'être* of human rights. One never hears an argument for a rights-based approach to fair trials. But a rights-based approach to fair trials which only *implicitly* includes the right to a fair trial is inconceivable. If there were a rights-based approach to fair trials, the explicit right to a fair trial would have to be at its center. Of course the parallel is not exact, but a rights-based approach to health that only *implicitly* includes the right to health lacks credibility and legitimacy. After all, the right to health is in the Constitution of the World Health Organization, all states have ratified one or more treaties which include the right, and it has been recognized by the UN on innumerable occasions.⁶

Playing down the right to health may not matter if other human rights within a rights-based approach possess all the features enjoyed by the right to health, but they do not. The right to health has distinctive characteristics which are indispensable for the effective implementation of a rights-based approach to health. Adopting a rights-based approach, and muting the right to health within it, runs the risk of diminishing both the approach and the right to health. Also, it may perpetuate what Yamin and Cantor refer to

as "an erroneous conception of human rights that is limited to a narrow sphere of civil and political rights."⁷ All of this points to the importance of legal interpretive methodology: if the right to health has distinctive features, their interpretation (i.e., establishing the contours and content of these distinctive characteristics) becomes crucially important.

In this article, I trace the shifting place of the international right to health, and human rights-based approaches to health, in the scholarly literature and United Nations. Second, I explore evidence that the international right to health is played down within a rights-based approach to health. Third, I analyze the degree to which the international right to health has qualities not possessed by other rights that form part of a rights-based approach to health. Because of the importance of these distinctive qualities, I then explore legal methodology for the interpretation of the international right to health. After critiquing the methodology that John Tobin uses to interpret the international right to health, I suggest that the "special character" of human rights treaties permits distinctive methods of treaty interpretation, while remaining within the interpretative boundaries established by the Vienna Convention on the Law of Treaties. I argue that the international right to health, as part of the rights-based approach to health, should be interpreted by way of these distinctive methods of treaty interpretation. In conclusion, I favor a rights-based approach to health which explicitly and consistently includes the international right to health.

It is helpful to distinguish (1) the international right to health, (2) human rights-based approaches to health, and (3) the national right to health; this article focuses on the relationship between (1) and (2), especially within the UN. However, the discussion also bears upon the right to health and human rights-based approaches to health within regions and countries. I use the "right to health" as a shorthand for the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," as enshrined in article 12 International Covenant on Economic, Social and Cultural Rights (ICESCR).⁸ "UN agencies" includes UN agencies, funds, programs, and similar

UN organizations. “General comments” includes general comments and general recommendations of UN human rights treaty bodies. The discussion focuses on specific developments in relation to health and human rights; however, it builds on generic initiatives in relation to economic, social, and cultural rights, such as the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights.⁹

Trends in the scholarly literature

The following survey focuses on monographs that examine either the right to health or human rights and health. In particular, it considers monographs that are scholarly, broadly understood; for example, it includes those from the meetings of scholars and policy makers, but excludes the campaigning material of civil society organizations. The focus is on key trends among monographs that give significant attention to international human rights standards.

Although the international right to health found its place in the UN in 1946, it was not subject to academic treatment until more than 30 years later. WHO’s first director-general, Brock Chisholm, was an energetic proponent of the right to health, and it was partly thanks to his leadership that the right was firmly established in the International Bill of Rights.¹⁰ But it was only in 1978—30 years after the Universal Declaration of Human Rights and 12 years after the ICESCR were adopted by the General Assembly—that eminent scholars, policy makers, and others explored the right to health in a three-day workshop organized by the Hague Academy of International Law and United Nations University. The proceedings were published in 1979 as *The Right to Health as a Human Right*.¹¹

In 1985, the University of Sherbrooke, Quebec, hosted a similar event which was followed by papers on the right to health in the *Revue Québécoise de Droit International*.¹² Four years later, the Pan American Health Organization published a voluminous study, *The Right to Health in the Americas*.¹³ Although mainly a comparative examination of constitutions from the region, the study has content on international law and was partly a response

to the 1978 Declaration of Alma-Ata, which affirms health as “a fundamental human right.”¹⁴

During 1992–1993, the American Association for the Advancement of Science held four day-long consultations on “the right to health care,” with a focus on the United States, which contributed to Audrey Chapman’s *Exploring a Human Rights Approach to Health Care Reform* and an edited collection of papers on the same theme.¹⁵ One striking feature of these publications is that they give considerable attention to both the international right to health, or health care, and a human rights approach. Given resistance in the United States to the right to health, it was considered strategic to place this right within a human rights approach.

In 1993, there were two other significant meetings on the right to health. In September, the Human Rights Program at Harvard Law School and the François-Xavier Bagnoud Center for Health and Human Rights at Harvard School of Public Health brought together a small group of people, mainly academics, for a one-day discussion on economic, social, and cultural rights, with a particular focus on the right to health. Formal papers were not presented, but a record of the discussions was published in 1995.¹⁶ Second, in December 1993, the UN Committee on Economic, Social and Cultural Rights held a public “Day of General Discussion on the Right to Health” which focused on the meaning to be attributed to article 12 of ICESCR. When presenting a working paper to his colleagues, committee member Alvarez Vita remarked that “although there was an abundant bibliography on health, very little of it related to health as a human right.”¹⁷

The groundbreaking *Health and Human Rights: An International Journal* was launched by the François-Xavier Bagnoud Center for Health and Human Rights in 1994. The first issue’s main article, “Health and Human Rights,” one of the most seminal in the field, mentions the right to health only twice: once in relation to the preamble of WHO’s Constitution and again when the article refers to “the specific health-related responsibilities of states listed in Article 12 of the ICESCR,” a choice of words that avoids “right to health responsibilities.”¹⁸ However, the issue’s second article is an

important piece on the international right to health in which Virginia Leary underscores that “there have been few serious efforts by international organizations or scholars to consider the scope of the right to health.”¹⁹

In summary, the emphasis of the relevant literature changed around 1993–1994. Beforehand, the relatively spare literature focused on the right to health; in 1993–1994, it began to lean toward human rights and health. This shift in emphasis is reinforced in the context of HIV/AIDS—for example, the *International Guidelines on HIV/AIDS and Human Rights*, adopted in 1996, refer to a “human rights approach” and “rights-based response,” and the 1997 book *Human Rights and Public Health in the AIDS Pandemic*, by Lawrence Gostin and Zita Lazzarini, focuses on a human rights approach.²⁰

A brief word is needed about the contribution of WHO. Health and human rights, including the right to health, was on WHO’s agenda until 1953, when a change of leadership effectively suspended for many years its serious and sustained consideration within the organization.²¹ In 1993, WHO published Rebecca Cook’s *Human Rights in Relation to Women’s Health*, which raised issues that contributed not only to the World Conference on Human Rights (1993), for which it was written, but also to the International Conference on Population and Development (1994) and Fourth World Conference on Women (1995).²² Four years later, WHO held a two-day informal consultation on health and human rights which the chairperson described as “the first meeting at WHO to be convened specifically to address health and human rights.”²³ In one of the meeting’s key papers, Julia Häusermann presented a conceptual framework for the right to health.²⁴

In 1999, Brigit Toebe wrote the first single-author book on the international right to health.²⁵ Here, for the first time, was a detailed, coherent, critical examination of the international right to health that looked at its historical origins, legal content, and international supervision and justiciability; it also appended a draft general comment on article 12 of the ICESCR. This pioneering book was published about fifty years after the right to health was first discussed in the United Nations.

Toebe’s analysis has limits: for example, it provides neither a philosophical justification for the right to health nor a clear interpretative methodology.²⁶ Nonetheless, it is an exceptional contribution to the literature, and the following year, after extensive consultations, research, and discussions, the Committee on Economic, Social and Cultural Rights adopted General Comment No. 14 on the right to health. Although the committee did not adopt Toebe’s draft general comment, her scholarship and draft emboldened the committee, informed its thinking, and contributed to its work.

There was another shift in the literature around 1999–2000. Before that time, the quantity of literature on either the right to health or human rights and health was limited. But in the seventeen years since the turn of the century, there has been a steady stream of academic books, articles, reports, and other publications on human rights and health, including the right to health. The contrast between the two periods—before and after 1999–2000—is dramatic.

The post-2000 scholarly monographs on human rights and health, including the right to health, display a number of features. First, a minority of them focus on the right to health.²⁷ Second, most of the monographs base themselves on phrases like “human rights framework(s),” “rights-based approaches,” “health rights,” and “human rights.”²⁸ Third, there are small clusters of monographs (on the right to health or one of the other formulations) around certain topics—for example, medicines, sexual and reproductive health, poverty, and neglected diseases. Other topics include health care, litigation, mental health, international assistance and cooperation, women’s and children’s health, public health, global health, Europe, and neoliberalism. Fourth, several collections include contributions on a wide range of issues, beginning with *Health and Human Rights: A Reader*, edited by Jonathan Mann, Sofia Gruskin, and colleagues; also notable is *Health and Human Rights: Basic International Documents*, which runs over 550 pages.²⁹

In a different group are philosophical books that examine the foundations of health and human rights, such as Jennifer Ruger’s *Health and Social*

Justice and Sridhar Venkatapuram's *Health Justice*.³⁰ In 2015, Benedict Rumbold, in his survey of conceptions of the "moral right to health," observed that "since 2012 alone there has been a cluster of work on the right to health" and found that there is "increasing recognition of both the philosophical questions engendered by the idea of a human right to health and the potential of philosophical analysis to help in the formulation of better policy."³¹

In conclusion, prior to 1993–1994, a few conferences and publications examined the right to health, rather than a human rights-based approach (or similar formulation). They gave the international right to health a degree of respectability and began the long process of placing it on academic and policy agendas.³² After 1993–1994, the focus began to shift from the right to health toward a human rights-based approach. Finally, after 1999–2000, there was a dramatic increase in the amount of scholarship on both human rights-based approaches to health and the right to health.

It is beyond the scope of this article to examine in detail why this sea change occurred around 1999–2000. However, drawing from Colleen Flood and Aeyal Gross, reasons include the reduced ideological divide between civil and political rights, on the one hand, and economic, social, and cultural rights, on the other, after the Cold War; the recognition by many in the human rights movement that their relevance and credibility required them to take social rights more seriously; the recognition by those working on HIV/AIDS and on women's health of the potential of human rights to fortify their campaigns (e.g., the demand for universal access to antiretroviral therapies was grounded in the idea of health as a human right); transformative constitutionalism, especially in Latin America and South Africa, that included new constitutions often encompassing an explicitly justiciable right to health (which has generated a huge amount of case law in some countries); and the perception of human rights as a way to challenge the detrimental impact of neoliberal economic policies on health-related services.³³ These interrelated factors also contributed to developments within the UN, to which I now turn.

Key developments in the United Nations

In addition to the growing scholarly literature since 1999–2000, there have been significant health and human rights developments in the UN. There is considerable crossover between the literature and UN developments. For present purposes, the post 1999–2000 UN developments may be divided into two groups: those that focus on the right to health and those with wider formulations, such as human rights-based approaches to health, which include the right to health.

Right to health

The key right-to-health developments include the adoption of general comments by human rights treaty bodies. Among the most important of these general comments are General Recommendation 24 of the Committee on the Elimination of Discrimination against Women (1999), General Comments No. 14 (2000) and No. 22 (2016) of the Committee on Economic, Social and Cultural Rights, and General Comment No. 15 of the Committee on the Rights of the Child (2015), all of which focus on either the right to health or parts of the right to health, such as sexual and reproductive health rights.³⁴

The developments also include the reports of UN Special Rapporteurs on the right to health: myself (2002–2008), Anand Grover (2008–2014), and Dainius Puras (2014–to date). In brief, they have written thematic and mission reports, as well as reports on the "communications" or complaints they have taken up, with summaries of any replies received. The appendix to this article lists all the rapporteurs' thematic and mission reports to date. Also, it signals the themes reported on, such as neglected diseases, maternal mortality, medicines, mental health, noncommunicable diseases, and adolescent health, as well as the issues considered in each mission report. To date, the rapporteurs have written 32 thematic reports and 23 mission reports on the right to health.

Although this article does not aim to provide an overview or analysis of these reports, a few brief points are in order.³⁵ First, broadly speaking, the reports endeavor to interpret and apply the

international right to health, drawing from general comments, international and national case law, and academic and other literature. Second, where there are gaps in the jurisprudence, the reports suggest the way forward. For example, in 2007 the Human Rights Council asked the Special Rapporteur to prepare a report on health systems and the right to health. At that time, there was scarce guidance from the treaty bodies or elsewhere on this topic, and so the rapporteur turned to basic principles, analogous practice, and extensive consultations and began to fill this jurisprudential gap.³⁶ Third, the rapporteurs consult, discuss, and research widely before writing their reports. Fourth, their more than 50 thematic and mission reports provide a unique cache of insights into the interpretation and application of the international right to health. Lastly, although, as befits their UN mandate, rapporteurs focus on the international right to health, sometimes they refer to human rights-based approaches.³⁷

Human rights-based approaches

As discussed, one of the purposes of treaty bodies' general comments is to provide a bridge between short, legalistic treaty provisions and practice. However, it is a long way from one side of the river to the other. While general comments get some of the way, they cannot span the gap alone. The rapporteurs' thematic and mission reports may provide another arch to the bridge, but they, too, are unlikely to be sufficiently detailed, specific, and practical to reach the other side. Often drawing from *A Human Rights-Based Approach to Health*, adopted by WHO and OHCHR, some UN agencies have risen to the challenge by preparing further guidance on how to operationalize human rights in relation to range of health issues.³⁸ The guidance varies in several ways, such as provenance, specificity, and practicality. However, how high is the profile of the international right to health in this guidance? By way of illustration, three different forms of guidance are briefly considered. First, however, it is necessary to confirm some of the key features of the international right to health.

In 2009, Sofia Gruskin, Dina Bogecho, and Laura Ferguson conducted a review of scholarly and

other literature to identify the common elements of a rights-based approach, especially in the context of health.³⁹ In light of this survey, they propose a framework for assessing “institutional articulations” of rights-based approaches to health.⁴⁰ Their framework includes a “minimal list” of “specific norms and standards” to “facilitate operation” of a rights-based approach: availability, accessibility, acceptability, and quality (collectively known as AAAQ), participation, non-discrimination, transparency, and accountability. Participation, non-discrimination, transparency, and accountability are commonly associated with a range of human rights—that is, they are crucial elements of, but not distinctive to, the right to health. On the other hand, the AAAQ derive from the Committee on Economic, Social and Cultural Rights' General Comment No. 14—in other words, they are closely associated with the right to health.

As Gruskin and colleagues observe, their list is “minimal.” If the list is to capture the influence of the right to health, at least three more elements are needed: progressive realization, maximum available resources, and international assistance and cooperation.⁴¹ Thus, when examining the following guidance, I pay particular attention to AAAQ, progressive realization, maximum available resources, and international assistance and cooperation.

First, under the rubric of “Guidelines for Social Mobilization,” *A Human Rights Approach to Tuberculosis* was published by WHO in 2001, not long after the Committee on Economic, Social and Cultural Rights' adoption of General Comment No. 14 in mid-2000.⁴² The heart of the guidelines consists of a section entitled “What are human rights?” and another called “TB and human rights.” The former refers generally to the right to health, progressive realization, and maximum available resources, and makes an oblique reference to international assistance and cooperation. The latter has several subsections on TB and poverty, children, women, and similar groups and issues. Most of these subsections end with a few lines on the relevance of human rights to the issue under discussion—for example, the only human rights content in the subsection on poverty is a quote from article 25 of the

Universal Declaration of Human Rights.⁴³ Scattered throughout the guidelines are occasional references to the right to health and General Comment No. 14, including two of the elements of AAAQ (availability and accessibility). Importantly, the guidelines are not intended to be comprehensive and are one of the earliest attempts within the UN to apply human rights to a health condition.⁴⁴ Nonetheless, from today's vantage point, they appear weak. The right to health, and some of its key elements, are evident, but marginal.

Second, *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations* was published by WHO in 2014.⁴⁵ Twenty-four specific and practical recommendations, clustered under concepts such as privacy, participation, accountability, and AAAQ, arose from an impressive combination of health-related evidence, human rights norms, and good process. The guidance is a measure of how far health and human rights have traveled since the TB guidelines thirteen years earlier. As for the place of the right to health, AAAQ form a key part of the structure of the guidance, but international assistance and cooperation is mentioned only once, while progressive realization and maximum available resources are barely visible.⁴⁶ The guidance considers "human rights standards as they are directly or indirectly applicable to contraceptive information and services" and its annex D provides a list of 14 relevant human rights, including the right to health. The guidance mentions the right to health on a few occasions.⁴⁷ However, despite the prominence given to AAAQ, overall the right to health has a fairly low profile.

Third, in 2011 the Human Rights Council asked OHCHR to prepare *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity*.⁴⁸ The guidance was presented to, and adopted by, the council in 2012.⁴⁹ Perhaps because of its origins, this guidance has a different tenor than the other two illustrations. Predictably, its human rights content is much stronger than in the TB guidelines and its evidence base is weaker

than the guidance on contraception. Overall, the maternal mortality guidance gives significantly higher visibility to the right to health through a combination of references to the right, AAAQ, progressive realization, maximum available resources, and international assistance and cooperation. For example, it devotes a chapter to international assistance and cooperation.⁵⁰

In conclusion, it is unrealistic to expect health policy makers or practitioners to read either a treaty provision or its corresponding general comment and then grasp how they are to operationalize the right to health. More detailed, specific, and practical human rights guidance is essential. By way of illustration, this section has looked at three examples: two in which the right to health has a marginal or low profile and one in which the profile is significantly higher. Firm conclusions cannot be drawn from this small sample, but it does highlight some important questions—for example, does it matter whether the right to health is absent, marginal, or prominent? To answer that question, it is necessary to clarify the distinctive contribution of the right to health to a rights-based approach.

The distinctive contribution of the right to health

Drawing from Gruskin and colleagues, the previous section provided a checklist of key right-to-health features, such as progressive realization, maximum available resources, and so on. However, more substantively, what is the distinctive contribution of the right to health to a rights-based approach? What does it contribute that other rights, which usually form part of such an approach, do not?

Most health policies, programs, and interventions cannot be implemented overnight; they take time, often years. Also, they usually require extensive resources. In the case of low- and middle-income countries, these resources include development assistance. For these reasons, the international right to health encompasses progressive realization, maximum available resources, and international assistance and cooperation.⁵¹ These concepts do not enfeeble the right to health. On the contrary, they ensure that the right to health has

the conceptual and operational potential to make a sustained contribution to the implementation of complex and costly health interventions that inevitably take years to put in place and will usually be ongoing. Also, as discussed, general comments have increased the usefulness of the right to health by interpreting it as including AAAQ.⁵²

Most of the other international human rights that are part of a human rights-based approach to health, such as the rights to life, privacy, and the prohibition against torture and inhuman and degrading treatment, do not have progressive realization and these other features. Of course, these other rights have a vital role to play in human rights-based approaches. But, for the most part, they do not have the qualities that give the right to health an indispensable role in relation to many health interventions, such as the construction of a quality health system for all, the establishment of a program for contraceptive information and services, or the establishment of harm reduction strategies for intravenous drug users. With few exceptions, civil, political, economic, social, and cultural rights place both negative and positive obligations on duty-bearers. However, the law and practice of economic, social, and cultural rights provide a more refined and extensive treatment of positive rights (i.e., the duty to fulfill and aspects of the duty to protect) than is provided by civil and political rights. In short, the right to health is equipped to make a crucial and *distinctive* contribution to a human rights-based approach to health.

My argument is that the right to health has the conceptual and operational *potential* to make an indispensable and distinctive contribution, especially in relation to the implementation of complex, costly, and long-term health interventions. However, this potential is not yet fully realized. Building on recent progress, more work is needed to develop concepts and practices that will make the right to health more effective and useful to policy makers, practitioners, and others. For example, in the context of finite budgets, how can policy makers prioritize among health interventions in a manner that is respectful of the international right to health? In recent years, progress has been made

toward answering this question, but the issues are complex and invite additional consideration.⁵³ Further advancing the conceptual and operational development of the international right to health will require multidisciplinary collaboration.

In conclusion, according to Sofia Gruskin, Edward Mills, and Daniel Tarantola, “the right to health forms the basis for much of the present work in health and human rights.”⁵⁴ Paul O’Connell agrees: “a consensus has emerged on the centrality of health as a basic human right.”⁵⁵ While Thérèse Murphy tends to the same view—“the rights to health and to have access to health care can be at the centre”—she adds an important rider with which I concur: “but other rights need to be present too.”⁵⁶

The conceptual and operational contours and content of the right to health are becoming clearer, and there is a strong case that the right to health makes a contribution to human rights-based approaches by way of its distinctive features, such as AAAQ, progressive realization, maximum available resources, and international assistance and cooperation. However, this valuable contribution is unlikely to be realized unless the right to health, including its distinctive features, are explicitly recognized and consistently applied. As we have seen, there is some preliminary evidence that this is not happening in relation to some rights-based approaches to health. This is partly a failure of legal interpretation.

If the right-to-health provisions of a treaty are relevant, then, according to article 31 of the Vienna Convention on the Law of Treaties, they have to be “interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its objects and purpose.”⁵⁷ In other words, the distinctive features of the right to health cannot be ignored or applied on some occasions but not on others; they have to be interpreted and applied in “good faith,” in accordance with their “ordinary meaning” and “context,” and in light of the treaty’s “objects and purpose.” This does not mean that the drafters of human rights-based approaches to health must become international lawyers. But it does mean they are required to have regard to the interpreta-

tion (i.e., the meaning) of the international right to health, and its distinctive features. So I now turn to the issue of legal interpretation.

Legal interpretative methods

In 2009, Fons Coomans and colleagues complained that “scholarship in the field of human rights is often lacking in attention to methodology.”⁵⁸ In recent years, attention to human rights method has grown, including in relation to health. For example, a new interest in measuring the evidence of impact of human rights on the health and well-being of individuals and communities has led to consideration of multidisciplinary research and evaluation methods.⁵⁹ The increasing attention to human rights method may arise from two interrelated factors: a deepening interest in the practical operationalization of human rights and the growing multidisciplinary of human rights studies. Both factors are especially acute in relation to economic, social, and cultural rights.

The growing interest in human rights method extends to human rights *legal* method. Murphy regrets that human rights legal method has been “a non-topic ... more disregarded than studied.”⁶⁰ In *Health and Human Rights*, she argues that “engagement with human rights legal method is essential” and she puts it “at centre stage.”⁶¹

In *The Right to Health in International Law*, after helpful chapters on the history of the right to health and its conceptual foundations, Tobin devotes a chapter to a legal methodology for interpreting the international right to health.⁶² His methodology illustrates major issues concerning the legal interpretation of the international right to health, as well as economic, social, and cultural rights more generally. It highlights issues that arise when treaty bodies, special rapporteurs, and agencies endeavor to interpret and apply the international right to health. Thus, Tobin’s proposed interpretative methodology warrants examination.

In summary, Tobin argues that the act of interpretation “is an attempt to persuade the relevant interpretative community that a particular

interpretation of the right to health is the most appropriate meaning to adopt.”⁶³ The “interpretative community” includes a “much wider range of stakeholders” whose “interests and insights must be taken into account in the interpretative exercise—a process described as constructive engagement.”⁶⁴ By “interpretative community,” Tobin refers to states, health professionals, international organizations, nongovernmental organizations, religious groups, multinational corporations, and “members of the general community who may be affected by the reallocation of resources to realize the right to health.”⁶⁵ General community members appear to be included to ensure, for example, that the health budget is not privileged over those of education or housing. At the beginning of his discussion, Tobin says that states form “a core part” of his interpretative community and then later describes them as “the central actors.”⁶⁶ He explains that, to be persuasive, the interpretation must satisfy four criteria—“it must be principled, practical, coherent, and context sensitive”—each of which he discusses in some detail.⁶⁷ Tobin favors an approach that “accepts the need to entertain a certain level of deference to the varied and often potentially conflicting interests within the relevant interpretative community.”⁶⁸

Claire Lougarre is troubled by Tobin’s interpretative methodology for three reasons. First, she doubts whether “consensus” among his interpretative community “should be the way we define human rights law” and observes the existence of “dangers that appeals to consensus might create.”⁶⁹ Katharine Young also argues that “the consensualist approach to the interpretation of economic and social rights is beset with several limitations.”⁷⁰ The approach fails “because it makes legitimate only the lowest common denominator of international protection.”⁷¹ If Tobin were to object that he is not arguing in favor of consensus, Young also points out that replacing unanimity with what she calls “majority consensus” is also problematic “because of the inevitable tendency to prejudice the minority articulation of rights.”⁷² She reminds us that “the claims of minorities ... are a main reason for the

existence of rights” and concludes that “focusing on consensus alone thwarts the definition of economic and social rights.”⁷³

Lougarre’s second difficulty with Tobin’s interpretative methodology is that it does not provide a solution to resolve conflicting views within the interpretative community.⁷⁴ Third, she doubts that his interpretative methodology “offers legal certainty to rights-holders and duty-bearers.”⁷⁵

In my view, there are several additional difficulties with Tobin’s interpretative methodology. For example, he begins by saying his aim is to devise a methodology that produces a meaning, or interpretation, of the right to health, but later he says the “aim ... is to contribute to a dialogue with the interpretative community whereby an understanding *as to the practical implementation of the right to health* will be developed through consultation and negotiation” (emphasis added).⁷⁶ Of course, interpretation and implementation are (or should be) closely related. Nonetheless, they remain distinct exercises. Interpretation focuses on clarifying the contours and content of the right to health—in other words, what the right means. On the other hand, implementation may be understood as diverse practical measures—laws, policies, practices, interventions, and so on—designed to ensure its realization.⁷⁷ Put simply, one needs a method to interpret the right to health (e.g., article 12 of the ICESCR) and also a process to work out how to implement it in the context of a particular state party (e.g., taking into account article 2(1) of the ICESCR). Implementation measures are bound to vary from one state to another, not least because all countries are at different stages of progressive realization and have different resource capacities. Although the overarching meaning of the right to health is not static, it will be much more constant, across both countries and time, than its implementation measures. In short, Tobin’s interpretative methodology would be more coherent and credible if it more clearly distinguished between interpretation and implementation.

However, his methodology has a more serious defect. At no point does Tobin mention the

rights-holders for whom article 12 is of particular importance: those living in poverty. Of course, article 12 has universal application, extending to everyone in a state’s jurisdiction. But, like ICESCR in general, article 12 has special relevance to the impoverished. The better-off, through their superior financial and other resources, including what Pierre Bourdieu calls “social capital,” are in a much stronger position to enjoy the right to health than those living in poverty.⁷⁸ Accordingly, any interpretative methodology of article 12 that fails to even acknowledge those living in poverty is deeply flawed for two reasons. First, it will have failed to put in place effective arrangements within the interpretative (or implementation) process that permit the active and informed participation of those living in poverty. Second, it is unlikely to identify and address the substantive health issues that are priorities for the impoverished. In short, Tobin’s “interpretative community,” which includes states, multinational corporations, and religious groups, excludes the individuals and communities who should be at the procedural and substantive center of the interpretative exercise. Tobin includes “NGOs that invoke the language of the right to health” in his “interpretative community,” but this could mean organizations that are far removed from the realities or insights of those living in poverty.

Of course, it is challenging to ensure the active and informed participation of those living in poverty in either an interpretative or implementation process. Certainly, elites and their allies will cavil and resist. Nonetheless, there is a wealth of theory and practice from which to draw.⁷⁹ In *Localising Human Rights*, for example, Koen de Feyter outlines four links in a chain: community-based organizations, local human rights nongovernmental organizations, international nongovernmental organizations, and allies in governmental and intergovernmental institutions.⁸⁰ The essential starting point is to ensure that the impoverished are visible and, by one means or another, have space to speak. Regrettably, Tobin’s methodology provides for neither, which casts a long shadow over the rest of his analysis.

Distinctive methods for the interpretation of ICESCR

Tobin's methodology points to juridical issues concerning the legal interpretation of international economic, social, and cultural rights, including the right to health in the context of rights-based approaches.

International policy makers and international human rights bodies have only recently begun to routinely apply and interpret economic, social, and cultural rights. There are exceptions, such as the International Labour Organization and its adjudicative bodies. Also, the Committee on Economic, Social and Cultural Rights has been interpreting and applying economic, social, and cultural rights since the late 1980s. Now that the Optional Protocol to the ICESCR has entered into force, the committee will have new opportunities to deepen its jurisprudence. Numerous UN Special Rapporteurs have interpreted and applied a range of economic, social, and cultural rights in relation to many themes and duty-bearers. Guidelines on international economic, social, and cultural rights are increasing.⁸¹ Nonetheless, on the whole, the international interpretation and application of these human rights is a relatively recent enterprise. As international economic, social, and cultural rights, including the right to health, gain currency, methodologies for their interpretation will have to address the relationship between public international law and international human rights law.

International human rights law is almost universally understood as a distinct subdiscipline of the broader, more general public international law.⁸² However, the relationship between the two domains "is a complex narrative of tension, evolution and juxtaposition."⁸³ While public international law is "traditionally considered as the rules and processes created by sovereign states to govern their interactions with each other," international human rights law is essentially concerned with placing entitlements on individuals and correlative obligations on states—in other words, the "constraint of state or public power."⁸⁴ As Scott Sheeran puts it, the origins of public international law are "inter-state,"

and the main focus of international human rights law is "intra-state."⁸⁵

Usually, international treaties reflect a contractual paradigm characterized by reciprocity between states—that is, an "exchange of obligations" between states in relation to peace, disarmament, trade, and other international matters.⁸⁶ However, international human rights treaties do not conform to this paradigm because, as expressed by the UN Human Rights Committee, they "are for the benefit of persons within [the state's] jurisdiction."⁸⁷ According to Matthew Craven, "it does seem that the overriding 'contractual' paradigm is largely (if not wholly) inappropriate in the case of human rights treaties."⁸⁸

As already discussed, article 31 of the Vienna Convention on the Law of Treaties provides general rules of interpretation for all treaties, including human rights treaties.⁸⁹ Broadly speaking, there are three schools of thought—or "doctrinal divisions"—for treaty interpretation: the "textual," "intentions," and "teleological" approaches. Clapham observes that article 31 manages to combine all three.⁹⁰ Article 32 provides the "supplementary means of interpretation"—for example, the preparatory work of a treaty, or *travaux préparatoires*.

A further important rule of interpretation is *lex specialis derogat legi generali*: whenever two or more norms deal with the same subject matter, priority should be given to the norm that is more specific.⁹¹ Sheeran remarks that this maxim is relevant with respect to competing rules *between* public international law and international human rights law, and also *within* international human rights law.⁹² While the application of the rule of *lex specialis* needs considerable care, it may have relevance in the context of international human rights law and international economic, social, and cultural rights.

International human rights and other bodies have considered these challenging issues of interpretation.⁹³ Here, it is neither possible nor necessary to analyze these contributions. However, three judicial pronouncements are especially instructive. The Inter-American Court of Human Rights has confirmed that human rights treaties do not con-

form to the traditional paradigm of an exchange of obligations between states:

*In concluding these human rights treaties, the States can be deemed to submit themselves to a legal order within which they, for the common good, assume various obligations, not in relation to other States, but towards all individuals within their jurisdiction.*⁹⁴

The European Court of Human Rights provides more specific interpretative guidance:

*In interpreting the Convention regard must be had to its special character as a treaty for the collective enforcement of human rights and fundamental freedoms Thus, the object and purpose of the Convention as an instrument for the protection of individual human beings require that its provisions be interpreted and applied so as to make its safeguards practical and effective. ... In addition, any interpretation of the rights and freedoms guaranteed must be consistent with the "general spirit of the Convention, an instrument designed to maintain and promote the ideals and values of a democratic society."*⁹⁵

In its Advisory Opinion on the Genocide Convention, the International Court of Justice not only alludes to the convention's distinctive character and the inapplicability of the traditional contractual paradigm but also emphasizes the importance of the "high ideals" underpinning the treaty:

*Consequently, in a convention of this type one cannot speak of individual advantages and disadvantages to States, or of the maintenance of a perfect contractual balance between rights and duties. The high ideals which inspired the Convention provide, by virtue of the common will of the parties, the foundation and measure of all its provisions.*⁹⁶

In summary, there is a credible argument that the distinctive features (or "special character") of human rights treaties permit distinctive methods of interpretation, while remaining within the interpretative boundaries established by the Vienna Convention on the Law of Treaties. If that is correct, what are these distinctive methods?

Briefly, Sheeran advises that the "*corpus juris* of human rights features a dominant dynamic or teleological method of interpretation, which considers treaties as 'living' instruments, rather than tied to the original intent of states parties."⁹⁷ This *corpus* has developed without much reference to international economic, social, and cultural rights because, as discussed, it is only recently that international policy makers and international human rights bodies have begun to routinely apply and interpret international economic, social, and cultural rights. However, if the prevailing human rights interpretative method tends to favor a teleological approach, this tendency is likely to be even more pronounced in relation to international economic, social, and cultural rights. Article 2(1) of the ICESCR requires states to take steps "with a view to achieving progressively the full realization of the rights recognized in the present Covenant."⁹⁸ Thus, with its explicit focus on progression toward a goal, both the text and the apparent intentions of the parties point toward a teleological method of interpretation in relation to international economic, social, and cultural rights, including the right to health.

Apart from their different catalogues of rights, what are the major differences between the International Covenant on Civil and Political Rights (ICCPR) and ICESCR that have interpretative implications? Here, I confine myself to two. First, as is well known, the key textual provisions in the ICCPR and ICESCR establishing the overarching legal obligations of state parties are substantively different. For example, while article 2(1) of the ICCPR uses the language of "respect and ensure," article 2(1) of the ICESCR, as already discussed, requires states "to take steps, individually and through international assistance and cooperation ... to the maximum of [their] available resources, with a view to achieving progressively the full realization" of the enumerated rights. It should not be overlooked, however, that article 2(2) of the ICCPR requires states "to take the necessary steps ... as may be necessary to give effect to" the enumerated rights, a formulation with similarities (i.e., taking steps) to article 2(1) of the ICESCR.

Second, while the object and purpose of the two treaties have much in common, there is an argument that their objects and purposes are also different; if that is correct, article 31 of the Vienna Convention on the Law of Treaties requires those interpreting the treaties to give due weight to this difference. Looking at the ICESCR as a whole, it can be argued that the object and purpose animating the covenant is the reduction and elimination of poverty, what President Roosevelt called “freedom from want.”⁹⁹ Although a closer examination of the object and purpose of the covenant is needed, the tenor of the Committee on Economic, Social and Cultural Rights’ statement on poverty tends to support this argument.¹⁰⁰ Of course, it is important that those living in poverty enjoy the full range of civil and political rights, as well as economic, social, and cultural rights. Nonetheless, the ICESCR is arguably shaped by the object and purpose of reducing and eliminating poverty, while the ICCPR is not. If so, the Vienna Convention on the Law of Treaties calls for the two treaties to be interpreted in a different manner, quite apart from their obvious textual differences.¹⁰¹

In summary, there is considerable support for the proposition that the distinctive features of human rights treaties permit distinct methods of interpretation. In addition, if the ICESCR’s object and purpose is to reduce and eliminate poverty, that treaty may be interpreted differently from the ICCPR. As the ICESCR is increasingly applied, international policy makers and human rights bodies will need to pay close attention to the distinctive legal interpretation of this covenant, including the right to health in the context of rights-based approaches to health.

Conclusion

This article has argued that in relation to human rights and health, the current trend is from theory to practice and the general to specific—hence the recent practical guidelines on specific health issues, such as contraception, maternal mortality, and under-five mortality. It has also shown that, since about 1993–1994, there has been a trend in

the scholarly literature away from consideration of the right to health by itself and toward looking at health and human rights generally—that is, human rights-based approaches to health. On the whole, these trends are welcome; for example, there are some advantages in moving from a right to health toward a rights-based approach. However, this article has also argued, and demonstrated by way of preliminary evidence, that there are risks associated with the adoption of a rights-based approach to health.

In the context of health policies, programs, and interventions, the human right of most central relevance will usually be the international right to health. The right has some features which make it especially well equipped to contribute to the effective implementation of health policies and interventions, over the medium and long term, in countries with different resource capacities. A risk arising from a human rights-based approach is that the right to health may become marginal within such an approach. Indeed, there is some preliminary evidence that this is happening. This might occur because the international right to health is not well understood. Also, in some quarters, there is ideological resistance to the right to health, in which case it may be convenient to “bury” the right within a human rights-based approach. For whatever reason, if the right to health does not explicitly play a central role in a rights-based approach, this is likely to weaken such an approach, diminish the right, and reinforce misconceptions about, and the marginalization of, economic, social, and cultural rights generally.

Thus, the preferred strategy is a rights-based approach to health that consistently and explicitly includes the international right to health. Certainly, giving the international right to health an explicit and central role within a rights-based approach will complicate some discussions. For example, it will become necessary to (1) distinguish between those human rights that are, and are not, subject to progressive realization; (2) explain that the right to health places more demanding obligations on high-income than low-income countries, except there are some “core obligations” that apply uni-

formly to all countries (e.g., non-discrimination, equitable access, and the adoption of an effective, participatory health strategy that gives particular attention to the disadvantaged); (3) confirm that states and others “in a position to assist” have a responsibility to provide international assistance and cooperation in health, especially to low-income countries; (4) explain that duty-bearers are accountable for their right-to-health obligations, including optimal progressivity, just as they are their obligations under the right to a fair trial; and (5) acknowledge that while effective health monitoring is important, it is not the same as accountability.¹⁰²

In this way, however, myths may be dispelled and rights-holders and duty-bearers may better grasp that the international right to health is not just exhortatory or rhetorical; on the contrary, it can help to improve the health and well-being of individuals, communities, and populations.¹⁰³ But this is unlikely to happen if the international right to health is placed on the fringes of a human rights-based approach, only implicitly present or “smuggled” in without discussion.

This is why legal interpretation is important. If the international right to health is to be applied, it needs to be explicitly placed in the center of a rights-based approach and interpreted in accordance with public international, and international human rights, law. The meaning of article 2(1) of the ICESCR—including the concepts of progressive realization, resource availability, and international assistance and cooperation, as well as AAAQ—needs careful discussion, interpretation, and application. These phrases and concepts are not yellow post-its: they have substantive content. Also, consistent with the Vienna Convention on the Law of Treaties, attention must be given to the ICESCR’s object and purpose, which probably include the reduction and elimination of poverty. Of course, such an interpretative exercise will be challenging because neither the meaning of the right to health nor the methods for its interpretation are settled. However, it is only by explicitly putting the right to health at the center of rights-based approaches to health, and by discussing its interpretation and application, including discussions with those living in

poverty, that the right can mature and consolidate its place in the international code of human rights.

Acknowledgments

I am very grateful to Danilo Curcic, Rebecca Wallace, Eibe Riedel, Thérèse Murphy, Rajat Khosla, Giulia Giannuzzi, Sabine Michalowski, and anonymous reviewers. However, the views in the article are mine, and any mistakes are my responsibility.

References

1. See Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS, *International guidelines on HIV/AIDS and human rights: 2006 Consolidated version* (Geneva: OHCHR and UNAIDS, 2006); World Health Organization (WHO), *Guidelines for social mobilization: A human rights approach to tuberculosis* (Geneva: WHO, 2001); OHCHR, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, UN Doc. A/HRC/21/22 (2012); OHCHR, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, UN Doc. A/HRC/27/31 (2014); WHO, *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations* (Geneva: WHO, 2014); WHO, *WHO guidelines on the management of health complications from female genital mutilation* (Geneva: WHO, 2016).
2. J. Harrington and M. Stuttaford, “Introduction,” in J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (London: Routledge 2010), p. 5.
3. A. Yamin and R. Cantor, “Between insurrectional discourse and operational guidance: Challenges and dilemmas in implementing human rights-based approaches to health,” *Journal of Human Rights Practice* 6/3 (2014), p. 453.
4. WHO and OHCHR, *A human rights-based approach to health* (n.d.).
5. F. Bustreo, P. Hunt, S. Gruskin, et al., *Women’s and children’s health: Evidence of impact of human rights* (Geneva: WHO, 2013), p. 20.
6. Constitution of the World Health Organization, UN Doc. E/155 (1946), preamble; P. Hunt, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur, Paul Hunt, submitted in accordance with commission resolution 2002/31, UN Doc. E/CN.4/2003/58 (2003).

7. Yamin and Cantor (see note 3), p. 466.
8. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966).
9. *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/CN.4/1987/17, Annex.
10. B. Meier, "Global health governance and the contentious politics of human rights: Mainstreaming the right to health for public health advancement," *Stanford Journal on International Law* 46/1 (2010), pp. 1–50.
11. R. Dupuy (ed), *Le Droit à la santé en tant que droit de l'homme / The right to health as a human right* (Amsterdam: Sijthoff and Noordhoff, 1979).
12. *Revue quebecoise de droit international*, vol. II (Montreal: Editions Themis, 1985).
13. Pan American Health Organization, *The right to health in the Americas: A comparative constitutional study* (Washington, DC: Pan American Health Organization, 1989).
14. International Conference on Primary Health Care: Declaration of Alma-Ata, Alma-Ata, September 6–12, 1998, para. I.
15. A. Chapman, *Exploring a human rights approach to health care reform* (New York: American Association for the Advancement of Science, 1993); A. Chapman (ed), *Health care reform: A human rights approach* (Washington, DC: Georgetown University Press, 1994).
16. Harvard Law School Human Rights Program, *Economic and social rights and the right to health: An interdisciplinary discussion held at Harvard Law School in September, 1993, organized by the Human Rights Program Harvard Law School and François-Xavier Bagnoud Center for Health and Human Rights Harvard School of Public Health* (Harvard: Harvard Law School Human Rights Program, 1995).
17. Committee on Economic, Social and Cultural Rights, Summary record of the 41st meeting, UN Doc. E/C.12/1993/SR.41 (1993), para. 4.
18. J. Mann, L. Gostin, S. Gruskin, et al., "Health and human rights," *Health and Human Rights: An International Journal* 1/1 (1994), p. 19.
19. V. Leary, "The right to health in international human rights law," *Health and Human Rights: An International Journal* 1/1 (1994), p. 26.
20. Commission on Human Rights, Guidelines on HIV/AIDS and human rights, UN Doc. E/CN.4/1997/37 (1996), p. 14; L. Gostin and Z. Lazzarini, *Human rights and public health in the AIDS pandemic* (New York: Oxford University Press, 1997), p. xv.
21. Meier (see note 10).
22. R. Cook, *Human rights in relation to women's health* (Geneva: World Health Organization, 1993), WHO/DGH/93.1.
23. I. Herrell, opening remarks (WHO Informal Consultation on Health and Human Rights, Geneva, December, 4–5, 1997), copy on file with the author.
24. J. Häusermann, *The right to highest attainable standard of physical and mental health: Conceptual framework*, Working paper for WHO Informal Consultation on Health and Human Rights, Geneva, December 4–5, 1997.
25. B. Toebes, *The right to health as a human right in international law* (Cambridge: Intersentia, 1999).
26. J. Tobin, *The right to health in international law* (Oxford: Oxford University Press, 2012), p. 76.
27. For example, T. MacDonald, *The global human right to health: dream or possibility?* (Milton Keynes: Radcliffe Publishing, 2007); G. Ooms, *The right to health and the sustainability of healthcare: Why a new global health aid paradigm is needed* (Ghent: International Centre for Reproductive Health, 2008); A. Clapham et al (eds), *Realizing the right to health* (Zürich: Rüffer and Rub, 2009); G. Backman (ed), *The right to health: Theory and practice* (Lund: Studentlitteratur, 2012); L. Forman and J. Kohler (eds), *Access to medicines as a human right: Implications for pharmaceutical industry responsibility* (Toronto: University of Toronto Press, 2012); M. San Giorgi, *The human right to equal access to health care* (Cambridge: Intersentia, 2012); Tobin (see note 26); J. Wolff, *The human right to health* (London: W.W. Norton and Company, 2012); J. Zuniga, S. Marks, and L. Gostin (eds), *Advancing the human right to health* (Oxford: Oxford University Press, 2013); C. Flood and A. Gross (eds), *The right to health at the public/private divide: A global Comparative study* (Cambridge: Cambridge University Press, 2014); B. Toebes, R. Ferguson, M. Markovic, et al. (eds), *The right to health: A multi-country study of law, policy and practice* (The Hague: T.M.C. Asser Press, 2014). Since 2003, the University of Essex's Health and Human Rights Project has published numerous monographs on different aspects of the international right to health. Available at <https://www.essex.ac.uk/hrc/practice/health-and-human-rights.aspx>.
28. For example, P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Oakland: University of California Press, 2005); E. Wicks, *Human rights and healthcare* (Portland, OR: Hart Publishing, 2007); P. Hunt, with the assistance of R. Stewart, J. Bueno de Mesquita, and L. Oldring, *Neglected diseases: A human rights analysis* (Geneva: World Health Organization, 2007); S. Corrêa, R. Petchesky, and R. Parker, *Sexuality, health and human rights* (London: Routledge, 2008); J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (London: Routledge 2010); B. McSherry and, P. Weller (eds), *Rethinking rights-based mental health laws* (Portland, OR: Hart Publishing, 2010); A. Yamin, S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Harvard Human Rights Program, 2011); E. Beracochea, C. Weinstein, and D. Evans (eds), *Rights-based approaches to public health* (New York: Springer Publishing Company, 2011); M. Dudley,

D. Silove, and F. Gale (eds), *Mental health and human rights: Vision, praxis, and courage* (Oxford: Oxford University Press, 2012); B. Toebes, M. Hartlev, A. Hendriks, et al. (eds), *Health and human rights in Europe* (Cambridge: Intersentia, 2012); P. Hunt and T. Gray, *Maternal mortality, human rights and accountability* (London: Routledge, 2013); T. Murphy, *Health and human rights* (Oxford: Hart publishing, 2013); Bustreo et al. (see note 5); J. Sellin, *Access to medicines: The interface between patents and human rights; Does one size fit all?* (Cambridge: Intersentia, 2014); J. Lee, *A human rights framework for intellectual property, innovation and access to medicines* (London, New York: Routledge, 2015); A. Yamin, *Power, suffering, and the struggle for dignity: human rights frameworks for health and why they matter* (Philadelphia: University of Pennsylvania Press, 2016); A. Chapman, *Global health, human rights and the challenge of neoliberal policies* (Cambridge: Cambridge University Press, 2016).

29. J. Mann, M. Grodin, S. Gruskin, et al. (eds), *Health and human rights: A reader* (London: Routledge, 1999); S. Gruskin, M. Grodin, G. Annas, et al. (eds), *Perspectives on health and human rights* (London: Routledge, 2005); R. Cook and C. Ngwenya (eds), *Health and human rights* (Aldershot: Ashgate, 2007); Clapham et al. (2009, see note 27); M. Selgelid and T. Pogge (eds), *Health rights* (Aldershot: Ashgate, 2010); M. Grodin, D. Tarantola, G. Annas, et al. (eds), *Health and human rights in a changing world* (London: Routledge, 2013); Zuniga et al. (see note 27). See also S. Marks (ed), *Health and human rights: Basic international documents*, 3rd ed. (Cambridge, MA: Harvard University Press, 2013).

30. J. Ruger, *Health and social justice* (Oxford: Oxford University Press, 2009); S. Venkatapuram, *Health justice: An argument from the capabilities approach* (Cambridge: Polity, 2011); N. Daniels, *Just health: Meeting health needs fairly* (Cambridge: Cambridge University Press, 2008).

31. B. Rumbold, "Review article: The moral right to health; A survey of available conceptions," *Critical Review of International Social and Political Philosophy* 18 (2015), p. 1.

32. Meier (see note 10).

33. C. Flood and A. Gross, "Introduction: Marrying human rights and health care systems; Context for a power to improve access and equity," in C. Flood, A. Gross (eds), *The right to health at the public/private divide: A global comparative study* (Cambridge: Cambridge University Press, 2014), p. 2.

34. Committee on the Elimination of Discrimination against Women, General Recommendation No. 24, Women and Health, UN Doc. CEDAW/C/1999/I/WG.II/WP.2/Rev.1 (1999); Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000); Committee on Economic, Social and Cultural Rights, General Comment No. 22, The Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/

GC/22 (2016); Committee on the Rights of the Child, General Comment No. 15, The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24), UN Doc. CRC/C/GC/15 (2013).

35. P. Hunt and S. Leader, "Developing and applying the right to highest attainable standard of health: The role of the UN Special Rapporteur (2002–2008)," in J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (London: Routledge 2010), p. 28.

36. See P. Hunt, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/7/11 (2008); G. Backman, P. Hunt, R. Khosla, et al. "Health systems and the right to health: An assessment of 194 countries," *The Lancet* 372/9655 (2008), pp. 2047–2085.

37. For example, P. Hunt, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. E/CN.4/2006/48 (2006); A. Grover, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/65/255 (2010).

38. WHO and OHCHR (see note 4); see also note 1.

39. S. Gruskin, D. Bogecho, and L. Ferguson, "Rights-based approaches' to health policies and programs: Articulations, ambiguities, and assessment," *Journal of Public Health Policy* 31/2 (2010), pp. 129–145.

40. Ibid., p. 138.

41. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 2(1).

42. WHO (2001, see note 1).

43. Ibid., p. 10.

44. Ibid., p. 2.

45. WHO (2014, see note 1).

46. Ibid., p. 22.

47. Ibid., p. 10.

48. Human Rights Council Res. 18/2, UN Doc. A/HRC/RES/18/2 (2011).

49. OHCHR (2012, see note 1). The guidance was prepared by way of a consultative process which included many organizations and individuals, including the author of this article. As a consultant, Ali Yamin was the main author of the guidance.

50. Ibid., paras. 81–90.

51. See International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 2(1).

52. Committee on Economic, Social and Cultural Rights (2000, see note 34), para. 12.

53. See, for example, P. Hunt, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/62/214 (2007), paras. 12–17; S. Gruskin and N. Daniels, "Process is the point: Justice and human rights: Priority setting and fair deliberative process," *American Journal*

of *Public Health* 98/9 (2008), pp. 1573–1577; A. Yamin and O. Norheim, “Taking equality seriously: Applying human rights frameworks to priority setting in health,” *Human Rights Quarterly* 36/2 (2014), pp. 296–324.

54. S. Gruskin, E. Mills, and D. Tarantola, “History, principles, and practice of health and human rights,” *The Lancet* 370/9585 (2007), p. 451.

55. P. O’Connell, “The human right to health in an age of market hegemony,” in J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (London: Routledge 2010), p. 191.

56. Murphy (see note 28), p. 189.

57. Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, 8 I.L.M. 679.

58. F. Coomans, F. Grünfeld, and M. Kamminga, “A primer”, in F. Coomans, F. Grünfeld, M. Kamminga (eds), *Methods of human rights research* (Cambridge: Intersentia, 2009), p. 11. They acknowledge exceptions, such as T. Landman, *Studying Human Rights* (London, New York: Routledge, 2006) and T. Landman, E. Carvalho, *Measuring Human Rights* (London, New York: Routledge, 2009).

59. Bustreo et al. (see note 5); *Health and Human Rights Journal*, Special Issue: Evidence of the Impact of Human Rights-Based Approaches to Health 17/2 (2015).

60. Murphy (see note 28), p. 9.

61. *Ibid.*, pp. 8–9.

62. Tobin (see note 26), pp. 75–120.

63. *Ibid.*, p. 10.

64. *Ibid.*

65. *Ibid.*, p. 82.

66. *Ibid.*, pp. 81, 84.

67. *Ibid.*, p. 11.

68. *Ibid.*, p. 119.

69. C. Lougarre, “John Tobin, the right to health in international law,” *The Modern Law Review* 77/2 (2014), pp. 340, 341.

70. K. Young, *Constituting economic and social rights* (Oxford: Oxford University Press, 2012), p. 59.

71. *Ibid.*, p. 60.

72. *Ibid.*, p. 61.

73. *Ibid.*, pp. 62, 64.

74. Lougarre (see note 69), p. 341.

75. *Ibid.*

76. Tobin (see note 26), pp. 75, 77, 98.

77. P. Hunt, “Configuring the UN human rights system in the ‘era of implementation’: Mainland and archipelago,” *Human Rights Quarterly*, forthcoming.

78. P. Bourdieu, “The forms of capital,” in I. Szeman and T. Kaposy (eds), *Cultural theory: An anthology* (Chichester: Wiley-Blackwell, 2011).

79. C. Calhoun (ed), *Habermas and the public sphere* (Cambridge, MA: MIT Press, 1992); P. Friere, *Pedagogy of the oppressed*, new rev. ed. (London: Penguin Books, 1996); D. Narayan, R. Chambers, M. Shah, et al., *Crying out for change*

voices of the poor (New York: World Bank Publications, 2000); M. Sepúlveda, Report of the Special Rapporteur on extreme poverty and human rights on the right to participation of people living in poverty, UN Doc. A/HRC/23/36 (2013); Yamin (see note 28); H. Potts, *Participation and the right to the highest attainable standard of health* (Colchester: University of Essex, Human Rights Centre, 2008).

80. K. De Feyter, *Localizing human rights*, No. 2006/02, IOB Discussion Papers (Antwerpen: Universiteit Antwerpen, Institute of Development Policy and Management, 2006).

81. For example, Food and Agriculture Organization, *Voluntary guidelines to support progressive realization of the right to adequate food in the context of national food security* (Rome: Food and Agriculture Organization, 2005) and UNFPA, *A Guide to support National Human Rights Institutions: Country Assessment and National Inquiries in the Context of Sexual and Reproductive Health and Well-being* (New York: UNFPA, 2015).

82. M. Craven, “Legal Differentiation and the concept of human rights treaty in international law,” *European Journal of International Law* 11/3 (2000), p. 492.

83. S. Sheeran, “The relationship of international human rights law and general international law: a hermeneutic constraint, or pushing the boundaries?” in S. Sheeran and N. Rodley (eds), *Routledge handbook on international human rights law* (London: Routledge, 2013), p. 79.

84. *Ibid.*, p. 83.

85. *Ibid.*, p. 84.

86. Human Rights Committee, General Comment No. 24, Issues relating to Reservations Made upon Ratification or Accession to the Covenant or the Optional Protocols Thereto, or in relation to Declarations under Article 41 of the Covenant, UN Doc. CCPR/C/21/Rev.1/Add.6 (1994), paras. 8, 17; *Reservations to the Convention on the Prevention and Punishment of the Crime of Genocide, Advisory Opinion*, International Court of Justice Reports (1951), p. 23; *Loizidou v. Turkey (preliminary objections)*, Application No. 15318/89, European Court of Human Rights, Series A, No. 310 (1995), para. 70; *Advisory Opinion OC-2/82, The Effect of Reservations on the Entry into Force of the American Convention on Human Rights (Arts 74 and 75)*, Inter-American Court of Human Rights, Series A, No. 2 (1982).

87. Human Rights Committee (see note 86), para. 8.

88. Craven (see note 82), p. 497.

89. Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, 8 I.L.M. 679, art. 31.

90. A. Clapham, *Brierly’s law of nations*, 7th ed. (Oxford: Oxford University Press, 2012), pp. 352, 353. For the three approaches, see F. Jacobs, “Varieties of approach to treaty interpretation: With special reference to the draft Convention on the Law of Treaties before the Vienna diplomatic conference,” *International and Comparative Law Quarterly* 18/2 (1969), pp. 318–346; Clapham (2012, see note 90), p. 349.

91. Sheeran (see note 83), p. 86.
92. *Ibid.*
93. See International Law Commission, Fragmentation of international law: Difficulties arising from the diversification and expansion of international law; Report of the Study Group of the International Law Commission, finalised by Martti Koskenniemi, UN Doc. A/CN.4/L.682 (2006).
94. *Advisory Opinion OC-2/82*, Inter-American Court of Human Rights (see note 93), para. 29.
95. *Soering v. United Kingdom*, European Court of Human Rights, Series A, No. 161 (1989), para. 87.
96. *Reservations to the Convention on the Prevention and Punishment of the Crime of Genocide, Advisory Opinion*, International Court of Justice Reports (see note 93), p. 12.
97. Sheeran (see note 83), p. 102.
98. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 2(1).
99. F. Roosevelt, "Four freedoms speech," Annual Message to Congress on the State of the Union (June 1, 1941).
100. Committee on Economic, Social and Cultural Rights, Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/C.12/2001/10 (2001).
101. However, see E. Riedel, "New bearings in social rights? The communications procedures under the ICESCR," in U. Fastenrath, R. Geiger, D. Khan, et al., *From Bilateralism to Community Interest: Essays in Honour of Bruno Simma Bruno Simma* (Oxford: Oxford University Press, 2011), pp. 574-589.
102. In relation to (5), see P. Hunt, "SDGs and the importance of formal independent review: An opportunity for health to lead the way," *Health and Human Rights Journal*, *SDG Series* (2015).
103. Bustreo et al. (see note 5); *Health and Human Rights Journal*, Special Issue (see note 59).

APPENDIX

Thematic and mission reports prepared by UN Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

PAUL HUNT, 2002-2008

Thematic reports

The right to health: sources, contours, and content. The mandate holder's key objectives, themes, and specific issues.	Report to the Commission on Human Rights, February 13, 2003 (E/CN.4/2003/5)
Right-to-health indicators. Good practices. HIV/AIDS. Neglected diseases (and leprosy). Optional Protocol to the Covenant on Economic, Social and Cultural Rights.	Report to the General Assembly, October 10, 2003 (A/58/427)
Sexual and reproductive health. Poverty (and Niger's Poverty Reduction Strategy). Neglected diseases. Violence prevention.	Report to the Commission on Human Rights, February 16, 2004 (E/CN.4/2004/49)
Millennium Development Goals. Indigenous peoples. Child survival and indicators.	Report to the General Assembly, October 8, 2004 (A/59/422)
Mental disability.	Report to the Commission on Human Rights, February 11, 2005 (E/CN.4/2005/51)
Commission on Social Determinants of Health. Health professionals and human rights education. The skills drain: migration of health professionals.	Report to the General Assembly, September 12, 2005 (A/60/348)
Right to an effective, integrated health system accessible for all. Human rights-based approach to health indicators.	Report to the Commission on Human Rights, March 3, 2006 (E/CN.4/2006/48)
Maternal mortality. Access to medicines (responsibilities of states and pharmaceutical companies).	Report to the General Assembly, September 13, 2006 (A/61/338)
Health and human rights movement. Cases on the right to health and other health-related rights.	Report to the Human Rights Council, January 17, 2007 (A/HRC/4/28)

Prioritization. Impact assessments. Water and sanitation.	Report to the General Assembly, August 8, 2007 (A/62/214)
Health systems and the right to health.	Report to the Human Rights Council, January 31, 2008 (A/HRC/7/11)
Accountability. Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines.	Report to the General Assembly, August 11, 2008 (A/63/263)

Mission reports

Intellectual property and access to medicines. Trade in services and the General Agreement on Trade in Services. Impact assessments. Gender and trade. Technical assistance. Trade Policy Review Mechanism. Accessing countries to World Trade Organization.	Report to the Commission on Human Rights on Mission to World Trade Organization, March 1, 2004 (E/CN.4/2004/49/Add.1)
Poverty. Prevention, treatment, and control of diseases. Women's and children's health. Health-related policy frameworks (poverty reduction and non-discrimination). Availability, accessibility, and acceptability of health care. Health professionals. Water and sanitation. Availability of resources.	Report to the Commission on Human Rights on Mission to Mozambique, January 4, 2005 (E/CN.4/2005/51/Add.2)
Poverty, discrimination, inequality, and the right to health. Role of international community, civil society, and health professionals. Trade agreements. Environment. Mental health. Sexual and reproductive health. Ethnicity and culture (indigenous peoples).	Report to the Commission on Human Rights on Mission to Peru, February 4, 2005 (E/CN.4/2005/51/Add.3)
Participation, access to information, accountability, and health professionals. Health system financing. Corruption. Sexual and reproductive health. HIV/AIDS. Tuberculosis. Mental health. Environment. Roma.	Report to the Commission on Human Rights on Mission to Romania, February 21, 2005 (E/CN.4/2005/51/Add.4)
Neglected diseases.	Report to the Commission on Human Rights on Mission to Uganda, January 19, 2006 (E/CN.4/2006/48/Add.2)
Detention. Mental health. Ethical obligations of health professionals. Force-feeding.	Report to the Commission on Human Rights on the situation of detainees at Guantanamo Bay, February 27, 2006 (E/CN.4/2006/120)
Protection of civilians during and after the conflict of 2006, and the right to health.	Report to the Human Rights Council on Lebanon/Israel conflict of August 2006, October 2, 2006 (A/HRC/2/7)
Integration of the right to health into domestic laws and policies. Access to appropriate health care. Mental health. The Sami. Harm-reduction for drug users. Human rights education and health professionals. Asylum-seekers and undocumented foreign nationals. International obligations in relation to the right to health and development. Health indicators. Disaggregation of data. Impact assessment.	Report to the Human Rights Council on Mission to Sweden, February 28, 2007 (A/HRC/4/28/Add.2)
Sweden's obligations of international assistance and cooperation in relation to the right to health. Sweden's role in Uganda, the World Bank, and International Monetary Fund. ³	Report to the Human Rights Council on Missions to Uganda, the World Bank, and the International Monetary Fund, March 5, 2008 (A/HRC/7/11/Add.2)
The government of Ecuador invited the rapporteur to appraise Colombia's aerial spraying of glyphosate along the Colombia-Ecuador border. The Rapporteur visited Ecuador (May 2007) and Colombia (September 2007).	The Rapporteur publicly presented his preliminary conclusions and recommendations at the end of both visits. ⁴ Subsequently, Ecuador issued proceedings against Colombia before the International Court of Justice. In these circumstances, the Rapporteur did not submit a full report to the UN Human Rights Council.
Access to medicines. Human rights responsibilities of pharmaceutical companies. Affordability of medicines. Effects of patents and licensing on access to medicines. Research and development: neglected diseases and pediatric formulations.	Report to the Human Rights Council on Mission to GlaxoSmithKline, May 5, 2009 (A/HRC/11/12/Add.2) ⁵
Maternal mortality.	Report to the Human Rights Council on Mission to India, April 15, 2010 (A/HRC/14/20/Add.2)

ANAND GROVER, 2008–2014

Thematic reports

Access to medicines. Impact of intellectual property rights on access to medicines.	Report to the Human Rights Council, March 31, 2009 (A/HRC/11/12)
Informed consent.	Report to the General Assembly, August 10, 2009 (A/64/272)
Same-sex conduct, sexual orientation and gender identity. Sex work. HIV transmission. Effects of criminalization on the right to health.	Report to the Human Rights Council, April 27, 2010 (A/HRC/14/20)
Impact of drug control on the right to health. Compulsory treatment for drug dependence. Access to controlled medicines. Human rights-based approach to drug control.	Report to the General Assembly, August 6, 2010 (A/65/255)
Access to medicines.	Report to the Human Rights Council, March 16, 2011 (A/HRC/17/43) 5
Development. Convergence of development, human rights and the right to health. Human rights-based approaches to development.	Report to the Human Rights Council, April 12, 2011 (A/HRC/17/2)
Right to health of older persons.	Report to the Human Rights Council, July 4, 2011 (A/HRC/18/37)
Impact of criminalization on sexual and reproductive health. Family planning. Education and information.	Report to the General Assembly, August 3, 2011 (A/66/254)
Occupational health.	Report to the Human Rights Council, April 10, 2012 (A/HRC/20/15)
Health financing and the right to health.	Report to the General Assembly, August 13, 2012 (A/67/302)
Access to medicines.	Report to the Human Rights Council, May 1, 2013 (A/HRC/23/42)
Right to health of migrant workers.	Report to the Human Rights Council, May 15, 2013 (A/HRC/23/41)
States and non-state actors' obligations toward persons affected by or involved in conflict situations.	Report to the General Assembly, August 9, 2013 (A/68/297)
Unhealthy foods and diet-related non communicable diseases.	Report to the Human Rights Council, April 1, 2014 (A/HRC/26/31)
Effective and full implementation of the right-to-health framework. Justiciability. Progressive realization and the enforcement of the right to health. Transnational corporations. International investment agreements. Investor-state dispute settlement.	Report to the General Assembly, August 11, 2014 (A/69/299)

Mission reports

Sexual and reproductive health. Harm reduction policies for drug users. Harm reduction policies and HIV/AIDS.	Report to the Human Rights Council on Mission to Poland, May 20, 2010 (A/HRC/14/20/Add.3)
Right to health of indigenous peoples. Detention.	Report to the Human Rights Council on Mission to Australia, June 3, 2010 (A/HRC/14/20/Add.4)
Inequalities and discrimination. Indigenous peoples. Women's right to health. Sexual and reproductive health. Violence against women. Access to medicines.	Report to the Human Rights Council on Mission to Guatemala, March 16, 2011 (A/HRC/17/25/Add.2)
Women's and children's health. Gender-based and family violence. Right to health of stateless persons and refugees. Detention.	Report to the Human Rights Council on Syrian Arab Republic, March 21, 2011 (A/HRC/17/25/Add.3)
Mental health. Maternal health. Malaria. Environment. Occupational health.	Report to the Human Rights Council on Mission to Ghana, April 10, 2012 (A/HRC/20/15/Add.1)
Access to medicines. HIV/AIDS. Criminalization of sex work and the use of drugs. Detention.	Report to the Human Rights Council on Mission to Vietnam, June 4, 2012 (A/HRC/20/15/Add.2)
Tuberculosis. Mental health. Domestic violence.	Report to the Human Rights Council on Mission to Tajikistan, May 2, 2013 (A/HRC/23/41/Add.2)
Tuberculosis. Detention.	Report to the Human Rights Council on Mission to Azerbaijan, May 3, 2013 (A/HRC/23/41/Add.1)
Right to health and nuclear disaster management.	Report to the Human Rights Council on Mission to Japan, July 31, 2013 (A/HRC/23/41/Add.3)

DAINIUS PŪRAS, 2014–CURRENT

Thematic reports

Overview of the mandate. Priorities in future work.	Report to the Human Rights Council, April 2, 2015 (A/HRC/29/33)
Child survival. Early childhood development.	Report to the General Assembly, July 30, 2015 (A/70/213)
Right to health of adolescents.	Report to the Human Rights Council, April 4, 2016 (A/HRC/32/32)
Sports and healthy lifestyles. Non-state actors' obligations. Good-practice approaches.	Report to the Human Rights Council, April 4, 2016 (A/HRC/32/33)
Sustainable development goals.	Report to the General Assembly, August 5, 2016 (A/71/304)

Mission reports

Health system financing. Vulnerable groups.	Report to the Human Rights Council on Mission to Malaysia, May 1, 2015 (A/HRC/29/33/Add.1)
Poverty and the right to health. Unsafe abortions. Sexual and reproductive health. Children deprived of liberty. Persons with disabilities. LGBT. People living with HIV/AIDS. Mental health policy. National health-care system.	Report to the Human Rights Council on Mission to Paraguay, May 24, 2016 (A/HRC/32/32/Add.1)
Rehabilitation and reintegration of women and children liberated from Boko Haram captivity.	Report to the Human Rights Council on Mission to Nigeria, 6 June 15, 2016 (A/HRC/32/32/Add.2)

For rapporteurs' thematic reports, as well as their reports on communications with governments and other actors, see <http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>.

For rapporteurs' mission reports, see <http://www.ohchr.org/EN/Issues/Health/Pages/CountryVisits.aspx>.

In addition to the above sites, Paul Hunt's reports (thematic, mission, and communications) can be found at <https://www.essex.ac.uk/hrc/practice/health-and-human-rights.aspx>.

References

1. Joint Report of the Chairperson-Rapporteur of the Working Group on Arbitrary Detention, Leila Zerrougui; Special Rapporteur on the independence of judges and lawyers, Leandro Despouy; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak; Special Rapporteur on freedom of religion or belief, Asma Jahangir; and Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt.

2. Joint Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Philip Alston; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt; Representative of Secretary-General on Human Rights of internally displaced persons, Walter Kalin; and Special Rapporteur on adequate housing as a

component of the right to an adequate standard of living, Miloon Kothari.

3. See also part V of the Report to the Human Rights Council on Mission to Sweden, February 28, 2007, A/HRC/4/28/Add.2.

4. Available at <http://www.essex.ac.uk/hrc/documents/practice/PaulHuntEcuadorColumbia2007.pdf>.

5. Summary report of the discussions held and the recommendations made at the expert consultation on access to medicines as a fundamental component of the right to health.

6. Joint Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras; Special Rapporteur on the sale of children, child prostitution and child pornography, Maud de Boer-Buquicchio; and Special Rapporteur on contemporary forms of slavery, Urmila Bhoola.