

VIRTUAL ROUNDTABLE

A Virtual Roundtable with Special Rapporteurs on the Right to Health

CARMEL WILLIAMS AND JOSEPH J. AMON

Introduction

Since 2002 the United Nations, through the (now) Human Rights Council, has mandated experts to advance the right to the enjoyment of the highest attainable standard of physical and mental health. Dr Tlaleng Mofokeng, is the fourth, and most recent appointment to this post, and the first woman to hold it. Called Special Rapporteurs, these ‘independent experts’ promote and protect the right to health throughout the world. They identify general trends related to the right to health, highlight specific challenges and recommend solutions, and undertake country visits to examine the situation concerning the right to health in a specific country. Each Special Rapporteur maps out their own priorities for the mandate, and selects which countries to visit. Their visits are not limited to countries, but can include institutions, for example, Paul Hunt undertook missions to the World Trade Organisation, World Bank, International Monetary Fund and a global pharmaceutical company (GlaxoSmithKline). To mark the occasion of the new appointment, HHRJ invited the four experts to participate in a virtual roundtable discussion about the mandate. In the following conversation, we ask the former mandate holders to reflect on their achievements and challenges, and the new incumbent to expand on her priorities and hopes for the role. A full list of all the thematic and country mission reports of the first three Special Rapporteurs is available on HHRJ’s resource page.¹

Participants

Paul Hunt (August 2002-July 2008)
Anand Grover (August 2008-July 2014)
Dainius Puras (August 2014-July 2020)
Tlaleng Mofokeng (August 2020—present)

Roundtable

CW and JA: Thank you so much for participating in this virtual roundtable discussion. Let’s start with some general introductions. Paul and Anand, you are both trained as lawyers and Dainius, you are a physician. What were you doing just prior to being appointed as the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health?

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Paul: I worked as a human rights lawyer, and lived, in Africa (Gambia), Israel/Palestine, Geneva, United Kingdom, and Aotearoa New Zealand. To begin with I focussed on civil and political rights but, in the 1990s, began to specialise in economic, social and cultural rights. Most of my work was in non-governmental organisations, like Liberty (UK), but also the Africa Centre for Democracy and Human Rights Studies (Gambia). Just before my appointment as Special Rapporteur, I served on the UN Committee on Economic, Social and Cultural Rights (1999-2002) while also working as a Senior Lecturer in Law at the University of Waikato, in Aotearoa New Zealand (1992-2000). In 2000, I was appointed Professor in law at the Human Rights Centre, University of Essex, UK.

Anand: Along with Ms. Indira Jaising, in 1981 I founded the Lawyer's Collective, a non-governmental (NGO) in India which promotes human rights, especially on issues relating to women's rights, HIV, tobacco, LGBT rights, sex workers rights, drug users and access to medicines. As a Senior Advocate, I practiced in the Supreme Court of India, and directed the HIV/AIDS Unit of the Lawyer's Collective. I argued several landmark cases in the field of human rights law, including mass eviction cases, environmental cases, HIV, and LGBT rights, as well as work in opposition to patents for essential life-saving drugs.

Dainius: Before my appointment (and during it) I was a professor and the *Head of the Centre for Child Psychiatry and Social Paediatrics at Vilnius University* in Lithuania. I had been engaged for some 30 years as a human rights advocate focused on transforming public health policies and services, with special focus on the rights of children, persons with mental disabilities, and other groups in vulnerable situations. I also served as chair of the board of two NGOs in Lithuania: the Global Initiative on Psychiatry, and the Human Rights Monitoring Institute.

CW and JA: Tlaleng, since you may be new to

many HHRJ readers, let's talk more about your background.² You began your health and human rights activism early, setting up a youth friendly clinic at the University of Kwa-Zulu Natal in the Eastern Cape of South Africa, as a student at the Nelson Mandela School of Medicine. Did you study human rights formally or did you see this as simply an extension of medicine?

Tlaleng: Medicine is a science that deals with rights to health, and although I am not a lawyer, I did learn about human rights in family medicine and one of the principles of medicine is "being an advocate for patients and understanding underlying causes of illness" and those two principles inform my work as a physician who is also an activist.

In 2010 I was deciding which specialty I would train in, and I chose sexual and reproductive health because I felt that it would provide me with the most variety of courses and issues and give me an opportunity to be both an activist and a doctor. I continue to see myself as both, running a clinic and producing video blogs dedicated to providing comprehensive information to enable people to make informed decisions about their fertility. I am also a facilitator and educator of youth, LGBTIQ individuals, HIV positive people, discordant couples, sex workers on issues such as consent, understanding their own risks depending on the type of sex they are engaged in, how to use the male and female condom, and extensive pre-contraceptive advice to empower for informed choices regarding suitable methods. This is deeply rewarding, but it remains frustrating that sexual and reproductive health and rights services and related rights are seen as a burden to most health systems and governments. It is exhausting to constantly have to fight for rights to dignity and autonomy, such basic principles yet they are the political battleground where people seek to control women.

CW: Let's talk about the start of your mandates. Every candidate for the position of a UN Special Procedure writes a 'motivation letter'. How did you describe your motivation when you were a candidate?

Paul: At the start of a brand-new and highly controversial mandate, I explained that I wanted to put the right to health on the map. One, by promoting the right to health as a fundamental human right. Two, by clarifying what it means. Three, by showing how it could be operationalised, that is, made real in the everyday lives of everybody. Explicitly woven throughout these objectives were two interrelated themes: poverty and discrimination.

Anand: My letter reflected my previous work on HIV, and highlighted a few issues that I felt urgently needed to be taken forward, namely, de-criminalization of behaviours, including sexuality related, drug use, sex work, HIV transmission, and access to medicines. I wanted these to be taken up at the international level.

Tlaleng: Like Anand, I emphasized my past experience, including my lived experience of being a woman, from the global south, in Africa, together with my expertise in the field of human rights and health, in working with government, global aid agencies, civil society, human rights institutions; working through data, investigations and hearings; recommending policy or legislative changes.

CW: Paul, briefly, you just referred to the role as a controversial mandate in 2002. Could you expand on that a little, and reflect on whether it remains so now?

Paul: The International Bill of Human Rights—consisting of the Universal Declaration of Human Rights (1948), International Covenant on Civil and Political Rights (1966) and International Covenant on Economic, Social and Cultural Rights (1966)—is one of the most important documents of the twentieth century. It has a wide and rich vision of humanity and human rights. For sure, there are striking omissions, some of which have now been redressed, for example, by the UN Convention on the Rights of People with Disabilities and the UN Declaration on the Rights of Indigenous Peoples. Nonetheless, the International Bill of Human Rights

has an expansive view of humanity, that is, it does not confine itself to civil and political rights, it also encompasses workers', social and cultural rights. But, for decades, many (not all) in the human rights movement lost sight of that wide and rich vision of humanity. For many, the focus narrowed to civil and political rights. Economic, social and cultural rights—especially social rights—became marginal. The right to health is a social right.

In 1990s, the narrow focus on civil and political rights began to shift. The UN determined to give more attention to workers', social and cultural rights. Appointing a Special Rapporteur on the right to health in 2002 was part of an incipient trend in the UN to reclaim this wide and rich vision of humanity and human rights.

However, today, this reclamation of social rights is still contested. The right to health does not fit well with an individualistic liberal ideology that favours non-interventionist government. The ideological opponents of social rights devise all sorts of arguments to keep social rights marginal. They argue that social rights, like the right to health, are not 'real' rights. Or they are only 'aspirational' and give rise to no obligations. Or, because they are subject to progressive realisation, they are not measureable.

Although these arguments of social rights 'deniers' are bogus, they confirm we have yet to reclaim the wide and rich vision of humanity and human rights that is the hallmark of the iconic International Bill of Human Rights.

JA: Looking back now, how do you view the aspirations you had at the onset of your appointment? Do you believe you achieved your goals by the end of your second term?

Dainius: In my first annual report, in June 2015, I summarized the substantial work done by Paul and Anand in articulating the right to health and highlighting key health and human rights issues.³ Both had done a terrific job on setting the foundations of the mandate, formulating the elements of the right to health framework, and elaborating on the issues that are central to the

right to health. My decision was to expand on themes that were becoming increasingly important, but had not yet been thoroughly addressed by the mandate or by the global right to health and human rights community. In that 2015 report I emphasized the importance of strengthening health systems, and the need to place the well-being of individuals and communities at the centre of health policies, ensure access to information and participation, and to have accountability mechanisms in place. Other issues I raised included the importance of a gender perspective, the rights of children and adolescents to health, as well as people in vulnerable situations, including mental health and well-being, and persons with disabilities. I introduced my focus on a life-cycle approach to the right to health. Overall, looking back, I think that I achieved a large part of what I planned to achieve.

Paul: Like Dainius, I achieved much of what I planned—with the help of a thousand others. Certainly, I made more progress with objective one (promoting the right to health) and objective two (clarifying what it means) than objective three (operationalising it). To operationalise the right to health we need savvy health professionals who get the right to health. Cops listen to cops. Judges listen to judges. Teachers listen to teachers. And health professionals listen to health professionals—and I am not a health professional. Anand and I are human rights lawyer-activists and, as the first right to health ‘rappers’, as I affectionately call mandate-holders, Anand and I made numerous distinctive contributions. Dainius and Tlaleng are health professionals and, building on the foundational work of many others, they are well-placed to operationalise the right to health. Dainius did a fantastic job, especially in relation to the right to mental health, and I am sure Tlaleng will be equally successful. Her professionalism, passion, and experience are exceptional.

Anand: Thank you Paul. I’m happy to be considered a distinctive health ‘rapper’. Overall, I felt I was able to achieve what I had set out to do. At first, I felt a little constrained in not having dedicated staff to

assist me in the work. As I had to earn an income as a professional lawyer, I found it difficult to continue what I had done with the first report without a dedicated team. Thereafter I got a dedicated team which was of enormous help.

CW: Tlaleng, do you have any particular themes or countries that you are planning to focus on in the first 18 months?

Tlaleng: It is too early to know about countries in our current pandemic, but I will centre ‘vulnerability as a human right’ and urge member states to focus on restoration of dignity in all their efforts to realise the right of everyone to the highest attainable standard of physical and mental health.

As Dainius mentioned, it is important to build on the work of one’s predecessors rather than attempt to redesign the wheel. It is also important to be strategic in our engagement with member states—drawing on previous successes and learning as we build on and advance the next phase of work. While each Special Rapporteur has his or her own area of expertise, we also have to look broadly, and be specific in recommendations. I can see it’s a balancing act!

I think partnering with others can be really effective—both civil society NGO partners, national, and UN partners. For example, in 2017 I briefed the UNFPA Executive Director and UN Secretary General’s Envoy on Youth on sexual and reproductive health and rights in the [African] region. I have also briefed the Independent Expert on the enjoyment of human rights by persons with albinism, on her country visit to South Africa, and in 2020, I was invited to a two-day meeting with the newly appointed UNAIDS Executive Director, during her global consultative process to inform the strategy for UNAIDS.

Collaboration within UN entities in promoting respect for human rights is crucial. In my current role as Commissioner at the Commission on Gender Equality (CGE), a national human right institution in South Africa, I led the country delegation to the 77th session presenting South Africa’s progress in March 2020.

JA: Paul, you mention promoting the right to health as your first objective and where you made the most traction. Can you describe more how you addressed this and what barriers you faced?

Paul: I am grateful to the *Health and Human Rights Journal* for carrying an article called “Interpreting the International Right to Health in a Human Rights-Based Approach to Health” in which I set out the evolution of the international right to health in the last few decades.⁴ As the article explains, until 2000 there was little clarity about what the right to health meant. There was not even a common vocabulary for discussing the key features of the right to health. Frankly, we were all over the place. This deficit was addressed by the UN Committee on Economic, Social and Cultural Rights in 2000 when it adopted General Comment 14 on the right to health.⁵ I had the privilege to serve on the Committee between 1999-2002 and helped to draft General Comment 14. Of course, General Comment 14 has its shortcomings but at least it outlines the contours and content of the right to health. It provides a map. An imperfect map—but a map, nonetheless.

I tried to apply General Comment 14 to thematic issues (for example, sexual and reproductive health, neglected diseases, the work of the World Trade Organisation, access to medicines, health systems, and so on) and real-life country situations (for example, in Uganda, Peru, Romania, Mozambique, Sweden, and elsewhere).⁶

By applying General Comment 14, I had to clarify and refine what the right to health means. In 2010, Sheldon Leader and I wrote an article “Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur (2002-2008)” which explores how I tried to clarify and refine the right to health.⁷ For example, I used my reports to explore how indicators and benchmarks can be used to hold governments accountable for the progressive realisation of the right to health. It’s not very exciting, but without indicators and benchmarks it is impossible to ensure that governments keep their promises to progressively realise the right to health. This work led to a major *Lancet* study on health sys-

tems and the right to health in 194 countries.⁸

I think it is fair to say that, thanks to the work of many, we now have a common vocabulary for understanding and talking about the right to health. Personally, I think it is extremely important this vocabulary is neither lost nor blurred. Of course, it will evolve and deepen. But it must not become a ‘lost’ language. If the common vocabulary for talking about the right to health loses its currency this will make life much easier for our ideological opponents, that is, the right to health ‘deniers’.

CW: Anand and Dainius, what would you consider the most important issue of your tenure?

Anand: For me, it was firstly the decriminalization of behaviours, such as sexuality, issues concerning the LGBTIQ communities, sex work, drug use, sexual and reproductive health and the criminalization of those behaviours and how that adversely impacts on the right to health. Rather than addressing the issues in silos, I had taken them broadly under the rubric of criminalization. These are included in two reports to the Human Rights Council presented in 2010 and 2011.⁹ These reports had a good impact amongst civil society and in some states as they started recognizing that criminalization is the wrong strategy to address behaviours. They started seeing linkages of common issues for themselves and some states responded positively. The reports strengthened the move towards decriminalization. The Global Commission on Drug Policy is a good example.¹⁰ Of course this was strengthened by my work in India, on Section 377 Indian Penal Code, covering sex work and drug use.

The second issue of importance was access to medicines. Civil society, academia, and states in low and middle income countries got a fillip with the reports on access to medicines.¹¹ It was no longer a technical issue which people could not understand. They could relate the report to their experience, on high drug prices which impacted adversely on access and availability to health goods, services and facilities.

Dainius: My priority was the right to mental health. I was ready for this challenge, which I think I had

been preparing for through my whole professional life. It is not for me to assess how effective my reports and other activities on mental health and human rights have been. Other experts are doing this and, hopefully will continue doing so in the future. But I am convinced that it was the right decision and the right time to address the failure of status quo in global mental healthcare. Mental health is emerging as a new priority, globally. The global community seems to have agreed that mental health needs more investment and parity with physical health, but we also need to decide how we should and should not invest. The messages from my reports are very clear about this.¹²

Some experts think that the messages I formulated are too radical, while other experts think that that I have made too many compromises with regard to assessing the status quo. It will be very interesting to observe how global mental health develops over the next 10 years.

CW: Paul and Anand, did you experience similar criticism from ‘experts’?

Paul: Yes, I did. Some philosophers said the right to health was ‘incoherent’. Some political scientists said the right to health was blind to political economy. Some economists said the right to health did not permit trade-offs between competing rights and other interests. Each criticism has to be taken seriously. There is a response to each one. When hearing these criticisms I would ask myself: the right to health can dignify and empower individuals and communities, is the critic trying to torpedo the right to health or is s/he trying to strengthen it?

I tried to protect myself from criticism by building on human rights values, law, literature and analysis, and by listening carefully to the disadvantaged, including those living in poverty.

Anand: I did not have much criticism from “experts” in the way that Dainius has mentioned, but I did face criticism from States. I protected myself from the negative impact of criticism by taking great care in two respects. In reports, the contents must be supported by evidence and properly ref-

erenced. No statement should be made without it being backed by an authoritative document or a record that is maintained by the mandate holder. Thematic reports should use evidence-informed references that support the point of view being advanced. In reports on country missions where claims can be contested, I consider it important to check that facts and comments are backed by somebody “on the ground, whose statement is recorded.” Also, all protocols which have been laid for issuing appeals, considering urgent appeals, and so on, must be followed. Don’t take short cuts!

CW: Were there issues that you feel you overlooked—and when did you discover this?

Paul: As my mandate came to an end, I wish I had given more attention to palliative care.

Dainius: The mandate is very broad, so it’s not realistic to cover many important themes. Besides my main priority, which was the right to mental health, I managed to produce thematic reports on the right to health in early childhood, the right to health in adolescence, the right to health and Agenda 2030, corruption and the right to health, deprivation of liberty and the right to health, health workforce and medical education, roles of sport and healthy life style in realization of the right to health. During the final months of my mandate, the COVID-19 pandemic started. Although there was not enough time for me to explore this issue, I managed to prepare my final report on the right to health and COVID-19. This report will be presented by my successor Tlaleng to the UN General Assembly in October this year.

I have addressed some other important issues (drug use, healthy food, right to health of LGBTI persons, right to health and TB) in my open letters and other statements. But, I wanted to do more on two issues—universal health coverage and palliative care. I regret that I did not manage to have full reports on these extremely important issues.

Of course, this is all mainly about process and about contributing to the visibility of the theme, formulating the position of the mandate and

strengthening the rights discourse and topics. In terms of measuring outcomes or impact of the role, I think now, as I did from the start of my tenure, that one mandate and one mandate holder cannot expect to achieve measurable change in the global right to health field. Rather, we make our contributions to the collective effort to the process of realizing the right to health.

Anand: I overlooked the role of business enterprises and philanthropic organisations. I had it in my mind all the time but I could not put it in my agenda as there was just too much to do. In light of Paul and Dainius' comments about palliative care, I joined with the Special Rapporteur on torture to make a recommendation that controlled medicines for palliative care are added to the WHO Essential Medicines list, and also included that recommendation in one of my reports.¹³

JA: What key partnerships did you feel helped you in your work? Did you collaborate with other mandate holders? With NGOs? Academics? UN agencies? Foundations? Others? Can you give examples of how these partnerships advanced your work?

Paul: My work depended on an extensive network of allies to whom I am forever indebted. For example, among my more successful country visits were to Peru and Sweden. In Peru, I had extraordinary support from the UN country team, especially PAHO and UNDP, as well as civil society. In Sweden, the support of civil society was exemplary. The visits were successful because of this support in Peru and Sweden. I had great support from a few brave souls within WHO. I must say that for six years I received top-notch sustained support from the OHCHR and Essex University colleagues.

Anand: NGOs who were working on the issues I was focusing on, providing key partnerships along with foundations who supported the consultations and meetings. This gave rigour to the thematic reports and also helped to build a support base on the issue, for example, on the migration report that I presented to the Human Rights Council in 2013 I

had a consultation with groups working on migrant worker issues in the Asia Pacific region.¹⁴ Similarly the report on the impact of criminalization of sexual and reproductive health, I had a smaller consultation with key actors on the ground.¹⁵ The consultations, on the one hand provided valuable inputs for the reports, while on the other they also developed a constituency to support the report and disseminate it.

I was also able to collaborate with other mandate holders on a few initiatives by issuing joint statements.¹⁶ But as mandate holders work on their own, it is difficult to join forces and do joint work.

Dainius: I believe our main partners are the states, because this reflects the mechanism and composition of the UN and the special procedures. The fact that mandate holders are independent (also from the UN) and have a right to go public, including with “naming and shaming”, creates a meaningful tension between the mandate holders and Member States. I think that this tension is one of major driving forces in the field of human rights, including for the right to physical and mental health.

Of course, other stakeholders, especially civil society, are of great importance. International and national NGOs were my main partners in all activities, especially during consultations when working on both thematic reports, and country missions. I devoted half of every day to meetings with civil society during the country missions. Space for civil society and mutually respectful cooperation between state agencies and civil society—these are crucial elements of the successful realization of the right to health.

JA: Can you describe a moment when you felt exalted in pursuing your work?

Paul: I decided to frame maternal mortality as a human rights issue and, when I presented this to the General Assembly, it was greeted with applause. I am pretty sure the applause was from observing NGOs, not states! But, in any event, the General Assembly is a very tough gig (it's as responsive as a bowl of porridge) so I really appreciated the pos-

itive reaction. The issue of maternal mortality and human rights led to thematic and country reports, for example, my mission to India, as well as other publications, such as a book called *Maternal Mortality, Human Rights and Accountability*.¹⁷

Anand: On my Vietnamese mission an issue arose relating to detention of sex workers. I was persistent in voicing my opinion about there being no need to detain them. On the final day the local MP in charge advised me that they would look into it more closely as they felt my arguments were persuasive.¹⁸

Dainius: The moments when I felt we were making progress were mainly related to responses to my thematic reports. Several reports—such as three reports on right to mental health (2017, 2019, 2020), the report on the right to health in early childhood, and another on adolescence, as well as those on corruption and right to health and on the health workforce and medical education—sparked a broad range of responses. Resolutions of the UN Human Rights Council on mental health and human rights, especially the one from 2020, was an obvious positive outcome of concerted efforts of Human Rights Council, Member States, OHCHR and mandate holders.¹⁹

CW: What about feeling despondent?

Anand: When I had issued an urgent appeal to Sri Lanka on retaliation against the Liberation Tigers of Tamil Eelam (LTTE), the Sri Lankan representative told me that they would make a complaint against me on my urgent appeal as they alleged I had not followed protocol. I felt the ground under my feet open up. I was sinking. Then I calmed down and called my official assistant in the OHCHR and asked her to send me all the correspondence relating to the urgent appeal we had issued. Fortunately, it showed that we had followed all instructions and protocol. I was then very angry at the Sri Lankan representative who had made a false accusation against me. But I maintained my cool, and advised him that he was out of line as he had not checked facts properly.

Paul: Early in my first term, I spoke to a large meeting of health professionals and, as the event proceeded, my heart sank because it was clear from expressions and body language that the majority had no idea what I was talking about, and the minority that grasped what I was talking about didn't much care for it.

It was very sobering but taught me that I had to adjust my approach and language without selling out. Without compromising on the right to health, I learnt to 'translate' right to health terms and concepts into terms and concepts that health professionals could relate to.

After meetings and over a drink I would tease my new colleagues by calling them 'lawless fetishists'. 'Lawless' because they attached scant importance to binding human rights law, and 'fetishists' because they were obsessively preoccupied by a bizarre and narrow understanding of what constitutes evidence.

Dainius: There were moments when it was difficult to defend the position I had formulated. But this is normal for most independent experts. The most difficult time for me was not so much related to my own mandate, but during the year (June 2018 - June 2019) when I was Chair of the Coordination Committee of all the Special Procedures. I could see how fragile the entire global situation about the protection of human rights is, and how important it is to defend the best of what humankind has achieved—the human rights of everyone, without exceptions.

CW: The understanding of the meaning of the right to health has deepened enormously since the first UNSR was appointed in 2002. What do you believe are the greatest gains in the development of, and our understanding of, the right to health over the past 20 years? Are there areas within the right to health that you would like to see further developed, either in policy, law, or operationally?

Paul: As mentioned, we have advanced our understanding of the right to health. We've clarified and developed General Comment 14 on the right to health, although there is still plenty of room

for improvement. Now the key priority is to build on this and make the right to health practical and operational in the everyday lives of everybody. The United Nations in Geneva and New York have a role to play in advancing this practical work, but it cannot be done in the corridors of the United Nations. Real-life practical implementation will occur on the ground in communities, clinics, hospitals, work places, housing estates, schools, universities, and elsewhere. Today, that's our priority challenge.

Dainius: In my view, the right to health has been well established as an economic and social right, and especially with regard to accessible, available, acceptable and good quality healthcare services. However, this has led to some imbalances and to selective approaches by many stakeholders. Many governments consider investment in healthcare services to be the most important aspect of the right to health. When I was planning official country missions, there were government expectations that first of all I would be visiting healthcare facilities and would be investigating whether medicines, vaccines and medical devices were available. This is, of course, an important element of the right to health. However, such an approach is too narrow and it may lead to excessive medicalization, to neglect of the social determinants of health, and to undermining broader human rights-based approaches. This led to my decision to address on several occasions the indivisibility and interdependence of all human rights, including civil rights and freedoms. Space for civil society, democracy, rule of law—these are crucial requirements for the effective realization of the right to health.

During the six years I held the mandate, (2014-2020) there were obvious signs of attacks on universal human rights principles in many parts of the world. My approach was that the right to health cannot be exercised without considering this broader context. For example, discrimination on very different grounds, within and beyond healthcare services, is detrimental to physical and mental health.

Some people commented that my approach moved away from a conventional interpretation of the right to health towards “human rights and

health”. But I deliberately chose that position. I am convinced that undermining any human right can be detrimental to right to health. And this is not only about inequalities and poverty being harmful for physical and mental health—which is well understood already. I spent more than 30 years in the Soviet Union, and I know how the undermining of civil and political rights is detrimental on public health. As a result, throughout my tenure, I often reminded states and others that all forms of violence and discrimination, on any ground, as well as shrinking space for civil society, is as damaging to health as are poverty and inequality. In other words, if attempts to achieve equality are made by force, and people are deprived of meaningful participation in this process, as happens in totalitarian and authoritarian regimes (an example was the forced collectivization of rural population in the Soviet Union), this is detrimental to the health and well-being of societies and individuals.

Anand: The greatest strength of the right to health is that the ICESCR is universally ratified. However, I don't think this right is understood by states, judges, lawyers, and activists. The fact that the right to health is a progressively realizable right makes it very complex. General Comment 14 doesn't clearly explain the concepts in a simple manner.

Moreover, there is criticism of its application. I still remember a judge of the Supreme Court of India asking me about a matter involving right to health - what could be done in the matter? There is hardly any jurisprudence on the right to health in India. I think there has to be huge effort to popularize the meaning of the right to health in simple language and also to address its critics. Secondly the areas of “respect, protect, and fulfil” have to be clarified in a simpler manner. There is a need for better and more consistent alignment of obligations. For example, with the Guidance on Business and Human Rights, protection of human rights is framed as a recommendation rather than acknowledging it is indeed a legal obligation.²⁰

Tlaleng: We need to ensure existing good laws inform policy and at the end of the day, must lead

to tangible and inclusive services and access. Many laws are great on paper but the impact on health outcomes isn't as expected. Locating issues of access, innovation, biomedical development, and research within a rights framework ensures accountability and that we truly leave no one behind.

CW: We are having this discussion in a particularly challenging moment, with many countries in lockdown as a result of the COVID-19 pandemic. Our last roundtable discussion highlighted the restrictions of rights that many are facing and challenges to accessing health care, education, justice as well as protection from violence and freedom of expression. But more broadly, we're also seeing a number of other trends harmful to realizing the right to health stemming from populism, increasing environmental crisis from climate change, and state and corporate efforts to dismantle social and economic rights. Violence and deadly health disparities, racism and invasive digital surveillance technologies often seem intractable and immune to rights claims. How well equipped do you think the rights movement is to address these challenges?

Anand: I don't think the human rights movement is able to challenge the dominant paradigm. Apart from restrictions that are imposed, which by the way have not been thoroughly challenged in courts of law, the fundamental right to equality and non-discriminatory access to health goods, services and facilities is being undermined by private non-state actors with the full backing of states. Vaccines and drugs are going to be given to those who are able to pay. Profiteering is the name of the game on diagnostics, drugs, and vaccines which result from research which has been publicly funded. It is like the old wild west out there.

Dainius: I have highlighted these issues during my tenure, and COVID-19 is demonstrating the indivisibility of human rights. Crises, such as the current one, present good opportunities for positive change. During my final months as special rapporteur when the COVID-19 pandemic started,

I could see some encouraging moves towards the revitalization of universal human rights principles, international solidarity, and multilateralism. On the other hand, many threats to human rights were activated. The most painful paradox in response to the public health crisis was that many stakeholders were escalating the importance of right to health at the expense of other rights, and especially civil rights and freedoms. I worked with other mandate holders to demonstrate that at all times—before, during, and after the pandemic—there is a need to strengthen, and not to weaken, broad human rights-based approaches. COVID-19 is a different pandemic compared to AIDS epidemics, but the principles of addressing such crises remain the same. The best “vaccine” is a human rights-based approach, and we all need to work hard on this.

Tlaleng: COVID-19 is exposing existing challenges and again and again it shows that we do not learn from history or previous disasters or health epidemics/pandemics.

JA: A number of critics have faulted the human rights movement for failing to address structural causes of rights violations. In many ways, it seems that the critique is that human rights advocates and institutions (national, international and non-governmental) or the protections and tools for accountability that these actors use are not sophisticated enough to combat privatization, financialization, deregulation, and the undermining of state systems of social protection and redistribution, that have produced deepening inequality and political and social crises around the world. Do you agree with these critiques?

Tlaleng: The main concern for me is the tendency to want to depoliticise the issues or the lives of the people and communities. The human rights movement did not cause oppressive systems, however, we must address structural causes of rights violations and name these systems so that we can be intentional about efforts to end them. We need to deepen understanding and be careful to not co-opt justice

language, intersectionality, inclusivity/diversity without matching that with action for what those frameworks mean. For example, we still accept race as a risk factor for ill-health when in fact it is racism that does that with spatial planning, poor access to water and sanitation, industries destroying indigenous land for capitalistic gains, leaving communities with pollution and poor health outcomes.

Dainius: I believe the human rights community has been doing its best in these difficult times of prolonged attack from different sides on universal human rights principles. I think that the most serious threat is coming from the “virus” of populist nationalism. Representatives of this widely spread wave try to pretend that they are fighting inequalities, and at the same time they reduce space for civil society, attack sexual and reproductive rights, escalate the concept of “protection of traditional family values”—all this is detrimental to the realization of the right to health. We need to strengthen the critical mass of those forces that defend and promote the best features of modern humankind—universal human rights principles that are embedded in the UDHR and in the UN conventions.

Anand: I don’t think it is an issue of lack of sophistication. It is simply that business is not made amenable to human rights. The fact is, for example, why are Business and Human Rights guidelines only voluntary? This is the core issue. Business entities who today control huge resources are without any real rights obligations. Unless that changes I don’t think there will be substantial progress.

JA: Even other Special Rapporteurs, such as Philip Alston, have painted a pessimistic portrait of respect for economic and social rights; for example, in his 2016 report to the Human Rights Council he said that the acceptance by States of ESC rights remains marginal and that that marginality is also reflected in the work of “many of the most prominent civil society groups focusing on human rights”. Is there any hope for optimism? What are some examples of civil society groups doing great work? Where have

you seen States take steps forward in terms of ESC rights?

Tlaleng: I will speak for my experience and what gives me hope and ideas on groups doing good work. Examples include National Human Rights Institutions (for example, the Commission for Gender Equality, South African Human Rights Commission), Section27, CALS, Nalane for Reproductive Justice, Iranti, Soul City Institute.

Anand: I think the marginality is due to the lack of understanding of ESC rights and primarily the concepts of progressive realization and underlying determinants. Unless these are clearly and simply spelt out, we are not going to get anywhere. Civil society groups also face the same problems. Very few groups are doing general ESC at the domestic level using international legal jurisprudence. At the State level I see South Africa moving forward but I think it is an exception.

Unfortunately, Special Rapporteurs are professional people who have to earn their living while they undertake time consuming work of the Special Rapporteurs. The workload is very high. It leaves little time for the Special Rapporteurs to do pedagogic work to explain the content of the right to health. This should be addressed in terms, for example, having meetings when on missions to explain the content and meaning of the right to health, especially in the academic and the legal world.

CW: If you think back to when you started the role, is there one piece of advice you wished you had received? Is this advice you would give to Tlaleng? Is there other advice you would give her relevant to this specific moment?

Paul: The right to health is a social right. In many quarters, there is an ideological resistance to social rights, including the right to health. All of us must be aware of this ideological resistance otherwise it is impossible to make sense of the obstacles we encounter in our work.

Dainius: My advice to Tlaleng would be to use the analytical right to health framework that Paul developed in his tenure. I think it is important not to lose the direction and guidance of this framework. But otherwise, each rapporteur must choose their own thematic priorities. The field of this mandate is so broad that it is impossible to cover everything. So each mandate holder adds with their own background, like I did with my approach and with a focus on mental health.

Anand: It would not be proper for me to “advise” Tlaleng. But as you have asked I am going to make a few points. I think she would have an idea about the issues she wants to push, primarily in terms of thematic reports which will overflow into her country missions. She should pursue those issues without being pressured by any states or civil society. It is important to have consultations with civil society actors and affected persons. That gives strong support on the ground which then augurs well when taking on the states on these issues. In reports it is good practice to make sure everything is supported by evidence and properly referenced. Finally, it is important that a mandate holder has good rapport with the assistants in Geneva. This helps ensure they are supportive of the mandate holder if difficult issues arise.

JA: Are there any ways that you think the mechanisms of the mandate should change? Is one Special Rapporteur addressing all aspects of the right to health really feasible? Are country missions worthwhile, and do they contribute to change within that state? What would be a good balance of thematic reports and country mission reports? Could they link in further to other accountability mechanisms, in terms of assessing state responses to the recommendations?

Anand: I was happy with the system of thematic reports and country missions. However, I think country missions need to be organized better. I think that there should be more time in the HRC and the Committees to exchange in dialogue. On country missions, apart from the plenary discus-

sion, there should be more time for rapporteurs and the country to interact in an open fashion.

Dainius: The methods used by mandate holders, and the rules set by the UN, are not perfect. But they are really good for creative work and for the independence of the mandate. The main concern now, with the pandemic and measures to address it, is that the special procedures survive this difficult time. The fact that mandate holders cannot travel is a very serious challenge, especially with regard to official country missions. We will need to find creative solutions so mandate holders can still fulfil this important aspect of their role.

Paul: The right to health cannot flourish if it is confined to national and international human rights systems, that is, the human rights ‘mainland’. The right to health must also be situated beyond this ‘mainland’-it must be scattered across ministries of health, UN agencies, business, civil society, and elsewhere, in what I call the human rights ‘archipelago’. The immense right to health challenge is to entrench this human right in both the human rights ‘mainland’ and its ‘archipelago’.²¹

CW: Tlaleng, do you have questions for the former Special Rapporteurs?

Tlaleng: How did you handle pushback?

Paul: I hesitate to say this, but I think the human rights movement, including the right to health, is experiencing pushback because human rights have lost their way. We have to reassert key human rights values, such as dignity, respect, decency, fairness, equality, freedom, and community. We have to do all we can to ensure our societies place these values at the centre of everything they do. These values are embodied in the International Bill of Human Rights. Human rights include, civil, political, workers’, social and cultural rights, as well as the right to a healthy environment, and indigenous peoples’ rights. We have to reclaim the universalism of human rights: they extend to everyone. Responsibility for human rights applies to all those wielding public

power, including powerful corporations. We have to insist on accountability for human rights, not in the law courts, but where we live and work. We need to demand evidence: according to the evidence, which policies and projects deliver human rights for everyone? If the policies don't deliver—change policy. If the policies deliver—keep going. We have to listen to the disadvantaged, including those living in poverty. As the Universal Declaration of Human Rights says, individuals have responsibilities to their communities (article 29(1)). We have responsibilities to each other, for example, not to be racist, and to future generations not to mess up our magical environment.

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