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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, submitted in compliance with Human Rights Council resolution 5/1, in which the Council decided that special procedures mandates were renewed until the date on which they would be considered by the Council according to the programme of work.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

The present report, submitted in accordance with Human Rights Council resolution 5/1, contains three main sections.

First, given a finite health budget, how does a State prioritize health interventions in a way that is respectful of human rights? Section II makes some preliminary observations on this complex question and urges all parties to give more attention to the challenging issue of health prioritization.

The Commission on Human Rights requested the Special Rapporteur to explore health impact assessments. Section III of the present report outlines a study he co-authored on that issue. It sets out a right-to-health impact assessment methodology and argues that such impact assessments are an aid to equitable, inclusive, robust and sustainable policymaking.

The right to the highest attainable standard of health encompasses medical care and the underlying determinants of health, such as water, sanitation, food, shelter and freedom from discrimination. There is a regrettable tendency to devote disproportionate attention to medical care at the expense of the underlying determinants of health.

Section IV focuses on two illustrative underlying determinants of health: access to safe water and adequate sanitation. It applies the right-to-health analytical framework to water and sanitation and makes a number of recommendations for States and other actors.

Contents

I. Introduction

1. By its resolution 60/251 of 15 March 2006, the General Assembly concluded the work of the Commission on Human Rights and established the Human Rights Council. The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to the highest attainable standard of health" or "right to health") is set out in Commission resolutions 2002/31 and 2004/27. The Human Rights Council, by its resolution 5/1, extended the mandate of the Special Rapporteur. The present report is submitted in accordance with that resolution.

2. In October 2006, the Special Rapporteur visited Peru, where he had meetings following up on his country mission of June 2004 (see E/CN.4/2005/51/Add.3). Following this visit, the Special Rapporteur sent a letter to the Government of Peru in August 2007 requesting further information about follow-up undertaken in response to the recommendations included in the report on his mission in 2004.

3. In February 2007, the Special Rapporteur visited Uganda. The mission had two principal objectives: to understand the role of Sweden, in particular the Swedish International Development Cooperation Agency, in relation to the highest attainable standard of health in Uganda; and follow-up to the mission that the Special Rapporteur had undertaken to Uganda in March 2005 (see E/CN.4/2006/48/Add.2). In October 2006, the Special Rapporteur also visited Washington, D.C., to meet the Nordic-Baltic Executive Directors at the World Bank and International Monetary Fund. The Special Rapporteur will submit a report thereon to the Human Rights Council.

4. In May 2007, the Special Rapporteur visited Ecuador. The mission to Ecuador was undertaken with the objective of investigating the health impact of the aerial spraying of glyphosate that has taken place along the border between Ecuador and Colombia; a report thereon will be submitted to the Council. In Ecuador, the Special Rapporteur also had consultations with civil society organizations on other right-to-health issues, regarding which the Special Rapporteur is preparing a letter to the Government. His correspondence, and any reply or replies from the Government, will be made public.

5. The Special Rapporteur visited Sweden in June 2007. The objective of the visit was to discuss the report on his mission to Sweden in January 2006, which was submitted to the Council at its fourth session, in March 2007 (A/HRC/4/28/Add.2). During his visit, the Special Rapporteur met with, inter alia, senior government officials and civil society representatives.

6. In November 2006, the Council, by its decision 2/108, requested the Special Rapporteur to identify and explore, from the perspective of the right to the highest attainable standard of physical and mental health, the key features of an effective, integrated and accessible health system. Between November 2006 and July 2007, the Special Rapporteur had a series of consultations on this issue with representatives of the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the United Nations High Commissioner for Human Rights (OHCHR); with non-governmental organizations, including Realizing Rights: the Ethical Globalization Initiative, Save the Children UK and Care-Peru; and with a number of academics, researchers and health

workers. The Special Rapporteur continues to research and hold consultations on the issue and will report to the Council thereon at a forthcoming session.

7. The Special Rapporteur has sent a number of urgent appeals and other communications to various Governments; he has also issued some press releases. He will report on the communications in his annual report to the Council.

8. Between January and July 2007, the Special Rapporteur participated in a number of meetings convened by international organizations, Governments and civil society. In January, he spoke at a meeting in London of the International Planned Parenthood Federation and also met with the Chairperson of the WHO Commission on Social Determinants of Health. In February, he attended the UNAIDS reference group meeting in Geneva and delivered a keynote speech at a Public Health Alliance conference in Belfast. In March, he spoke at an event, organized by the United Nations Population Fund and the Centre for Reproductive Rights, in New York, during the session of the Commission on the Status of Women, and delivered a lecture on maternal mortality and human rights at Trinity College, Dublin. During the same month, he visited the Netherlands, held consultations with Medecins Sans Frontières and spoke at the Universities of Tilburg and Utrecht. In March, the Special Rapporteur attended the fourth session of the Human Rights Council and gave a keynote speech at the Midsin Global Health Conference in Newcastle, United Kingdom. In April, he gave a talk at the international secretariat of Amnesty International and in May attended a meeting organized by Glaxo Smith Kline to discuss its role in providing access to HIV/AIDS medicines. In June, he attended the annual meeting of the Council special procedures, organized by OHCHR. During the same month, he gave a keynote speech at a conference held in Prato, Italy, organized by Monash University, Australia, and King's College, London, and also visited Poland to speak at a meeting organized by the Federation for Women and Family Planning. In July, he spoke at meetings in Wellington organized by the New Zealand Aid and International Development Agency, as well as the civil society organization Health Promotion Forum. He also taught on a health, development and human rights course organized by the Initiative for Health and Human Rights, University of New South Wales, Australia.

9. The Special Rapporteur continues to prepare draft guidelines for pharmaceutical companies on access to medicines and expects to have a draft for consultation in the coming weeks.

10. All United Nations documents relating to the work of the Special Rapporteur are available on the OHCHR website (www.ohchr.org/english/issues/health/right/). For ease of reference, these documents, selected conference papers and other information can also be found on the website of the Right to Health Unit, Human Rights Centre, University of Essex (www2.essex.ac.uk/human_rights_centre/rth.shtm).

II. Prioritization of health interventions and respect for human rights

11. Throughout his mandate, the Special Rapporteur has argued that the right to the highest attainable standard of health should shape, and be integrated into, relevant national and international policies. If this is to happen, new human rights

techniques and tools are needed. The traditional human rights techniques — "naming and shaming", letter-writing campaigns, using test cases, slogans and so on — are insufficient for the task. While they still have a crucial role to play in the vindication of the right to health,[1] alone they are not enough. One of the new techniques needed is a way of monitoring the progressive realization of the right to health. For that reason, the Special Rapporteur devoted a report in 2006 to a human rights-based approach to health indicators (E/CN.4/2006/48). Another tool that needs more attention is constituted by impact assessments; for that reason, the present report includes a section on that issue.

12. The integration of the right to health into national and international policymaking also presents other challenges. For example, faced with limited resources, decision makers have to choose between different health policies and programmes, all of which contribute in one way or another to the realization of the right to health. One of the most difficult questions the Special Rapporteur is asked while on country mission is: "Given a finite budget, how can the Minister of Health prioritize health interventions in a manner that is consistent with the Government's national and international human rights obligations?"

13. Over many years, the health community has generated extensive literature and practice on prioritizing and rationing health interventions. Cost-effectiveness and equity are among the principles used by health economists and ethicists to help guide policymakers through this difficult terrain. Although they have not solved the dilemmas (far from it), they have given the issues considerable attention.

14. By contrast, the human rights community has not yet given these important issues the sustained attention they deserve. With a few honourable exceptions, there is little human rights literature on the topic.[2] United Nations treaty bodies offer no detailed guidance on how States can prioritize in a manner that honours their binding human rights obligations.

15. This state of affairs is surprising, because priority-setting raises profound human rights issues. In practice, prioritization has often privileged the health needs of wealthy, urban populations over the entitlements of the rural poor. It has often marginalized the health entitlements of women, persons with disabilities and other disadvantaged groups. This mirroring and deepening of patterns of inclusion and exclusion is offensive to the right to the highest attainable standard of health.

16. Nonetheless, some still maintain that the human rights community should not involve itself in issues of prioritization. Their response to the prioritization problem is simple: allocate more resources to health.[3] This response is partly right. Many countries spend far less than the $34 per capita minimum health expenditure

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[1] For example, see the report of the Special Rapporteur of January 2007 (A/HRC/4/28), sect. III.

[2] Some literature and court cases address the issue, such as *Soobramoney* v. *Minister of Health*, Constitutional Court of South Africa, case CCT 32/97, 26 November 1997; and F. Alvarez-Castillo, T. K. Sundari Ravindran and H. de Pinho, "Prioritisation", in T. K. Sundari Ravindran and H. de Pinho, eds., *The Right Reforms? Health Sector Reforms and Sexual and Reproductive Health* (University of Witwatersrand, 2005).

[3] Consistent with the State's obligation, in article 2 (1) of the International Covenant on Economic, Social and Cultural Rights, to devote the maximum available resources to the right to health.

recommended by the WHO Commission on Macroeconomics and Health.[4] Thus, calls for greater investment in health, in both developing and developed countries, are usually entirely legitimate.

17. However, even when more resources are made available, it is unlikely that they will support all health needs. In other words, tough priority choices will still have to be made, although prioritization becomes meaningless if the available resources do not reach a basic minimum threshold. Consequently, a call for increased health resources — and nothing more — rarely satisfies those who wish to see the right to health animate policymaking processes.

18. The modest purpose of the present section is to urge all relevant parties to pay more attention to the complex, sensitive issue of how to set health priorities in a manner that is consistent with human rights, including the right to the highest attainable standard of health. With a view to stimulating this discussion, the paragraphs below provide some brief, preliminary observations.[5]

Preliminary observations

19. Prioritization demands close collaboration between human rights specialists and health specialists, including epidemiologists and health economists.

20. Human rights will sometimes signal a particular substantive health outcome from the process of prioritization, but more frequently they will suggest a series of procedural considerations (for example, participation, monitoring and accountability) that have to be taken into account when setting priorities.

21. It would be very difficult, if not impossible, for a health authority to apply the right to health to the issue of prioritization if it were not also integrating human rights throughout its responsibilities. In short, a health authority cannot properly apply the right to health to the process of prioritization in isolation.

22. The right to health includes entitlements to medical care and to underlying determinants of health, such as adequate sanitation, water, nutrition and housing. Therefore, priority setting across a range of sectors, and not just the health sector, will have a profound bearing on the right to health. This underscores the crucial importance of intersectoral collaboration for the delivery of the right to the highest attainable standard of health.

23. The human rights approach does not make the unreasonable demand that all human rights must be realized overnight. In recognition of present realities, including resource constraints, it allows for the progressive realization of the right to health over a period of time. Prioritization must be conducted in this context of progressive realization.

24. Consequently, priority-setting must take place within the framework of a comprehensive national health strategy that spells out how the State expects to

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[4] See Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (WHO, 2001).

[5] The information is based on papers prepared by Carla Clarke, Gunilla Backman, Rajat Khosla and Stephania Tripodi for an informal consultation organized by the International Federation of Health and Human Rights Organizations and the University of Essex in July 2005, as well as a draft chapter prepared by Judith Bueno de Mesquita later in the same year following additional consultations. Many thanks to all.

progressively implement the various elements of the right to the highest attainable standard of health. In turn, that strategy must be informed by a comprehensive and up-to-date baseline assessment of health status, and enjoyment of the right to health, throughout the jurisdiction.

25. Everyone has the right to participate in health-related decision-making that affects them.[6] The prioritization process must include the active and informed participation of all stakeholders, including marginalized groups, in agenda-setting, decision-making, and monitoring and accountability arrangements.

26. From the human rights perspective, priority-setting must give particular regard to improving the situation of populations, communities and individuals that are especially disadvantaged in the country in question, including those living in poverty. In other words, vulnerability and disadvantage are among the reasonable and objective criteria that must be applied when setting priorities. Regard must be given to both direct and indirect discrimination. Thus, data must be disaggregated as far as possible.

27. Monitoring and accountability mechanisms are needed in relation to the priority-setting process, as well as implementation of the selected priorities. For this purpose, appropriate indicators and benchmarks are essential.

28. The right to health includes some obligations of immediate effect that are not subject to progressive realization. These core obligations reflect minimum essential levels of the right to health, such as freedom from discrimination, the preparation of a comprehensive national health strategy, integrated primary health care (as set out in the Alma-Ata Declaration), and access to basic sanitation. Despite important insights provided by various authors, much more work still has to be done to clarify the content of these core obligations.[7] However, so far as they can be identified with sufficient clarity, the process of prioritization should not compromise the core obligations arising from the right to health.

29. Given the requirement of progressive realization, all elements of the right to health must at least maintain their current levels of implementation (the principle of "non-retrogression").

30. In line with their human rights responsibilities of international assistance and cooperation, donor countries should help developing countries prioritize in a manner consistent with the right to health. Donors and international organizations, including international financial institutions, should ensure that their policies and programmes support national priorities of recipient countries that have been decided by democratic and participatory processes.

Conclusions

31. **While human rights have a constructive contribution to make to prioritization, they are unlikely to provide neat answers to highly complex issues, any more than do ethics, economics or general theories of justice. They are likely to rule out some processes and some choices, leaving a number of options, all of which are legitimate.**

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[6] E/2001/22-E/C.12/2000/21, annex IV, general comment 14, para. 54.

[7] See *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Audrey R. Chapman and Sage Russell, eds. (Antwerp, Intersentia, 2002).

32. **The preceding paragraphs are simply preliminary points for discussion. Much more work is needed to explore in detail the philosophical and practical contribution of human rights to health priority-setting. As the health and human rights movement matures, it is very important that it respond to this challenge. Moreover, applying human rights to the prioritization process will dispel some common misunderstandings about the right to the highest attainable standard of health and help to establish the very extensive common ground between public health, medicine and human rights.**

III. Impact assessments and the right to the highest attainable standard of health

33. Any modern policymaker, unless purely driven by ideology, will wish to consider, in a balanced, objective and rational manner, the likely impact of a proposed new policy, especially on those living in poverty. Moreover, before a State introduces a new proposal, it must ensure that the initiative is consistent with its existing national and international legal obligations, including those relating to human rights.

34. In these circumstances, there is a growing demand for Governments to carry out human rights impact assessments prior to adopting and implementing new policies, programmes and projects. To date, however, relatively little work has been done to develop methodologies and tools to help Governments undertake human rights impact assessments.

35. In his initial report to the Commission on Human Rights in 2003, the Special Rapporteur explained that he wished to examine impact assessments and the right to health (E/CN.4/2003/58, paras. 82-85). In response, the Commission specifically requested the Special Rapporteur to pursue his analysis of health impact assessments.[8] Since then, he has looked at impact assessments in relation to trade rules and policies.[9] While on country missions, he has also raised the issue of impact assessments in appropriate cases.[10]

36. In 2006, the Special Rapporteur co-authored, with Gillian MacNaughton, a report on impact assessments, poverty and the right to the highest attainable standard of health.[11] The United Nations Educational, Scientific and Cultural Organization (UNESCO) funded the research.[12] The purpose of the project was to contribute to the development of a human rights impact assessment methodology, with a particular focus on the right to the highest attainable standard of health. The report is over 60 pages in length and includes four detailed annexes. The present section serves as a brief introduction to the full report.

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[8] See *Official Records of the Economic and Social Council, 2003, Supplement No. 3* (E/2003/23), sect. II.A, resolution 2003/28, para. 16.

[9] See E/CN.4/2004/49/Add.1, paras. 53-56.

[10] See, for example, A/HRC/4/28/Add.2, paras. 122 and 123.

[11] Paul Hunt and Gillian MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health* (UNESCO, 2006). The full report is available from the website of Essex University, Human Rights Centre, Right to Health Unit (www2.essex.ac.uk/human_rights_centre/rth/projects.shtm).

[12] The Special Rapporteur is most grateful to UNESCO and Ms. MacNaughton.

37. Human rights impact assessment is the process of predicting the potential consequences of a proposed policy, programme or project on the enjoyment of human rights. The objective of the assessment is to inform decision makers and the people likely to be affected so that they can improve the proposal to reduce potential negative effects and increase positive ones. Human rights impact assessment is a relatively recent concept. However, other forms of impact assessment, such as environmental and social impact assessments, are now well-established and routinely undertaken in many countries to evaluate proposed policies, programmes and projects. Similarly, such initiatives, prior to being adopted and implemented, should be assessed for their impact on human rights.

38. The report reviews and then draws key criteria from three pioneering human rights impact assessment initiatives: (a) the Handbook in Human Rights Assessment (2001) of the Norwegian Agency for Development Cooperation; (b) the Rights and Democracy initiative on human rights impact assessment (2007); and (c) the Health rights of women assessment instrument (2006) of the Humanist Committee for Human Rights.[13] The report focuses specifically on the obligation of Governments to undertake impact assessments in order to comply with their obligation to progressively realize human rights. Accordingly, it proposes a methodology specifically suited to assessments of governmental policies, programmes and projects.[13] Importantly, the methodology is intended to assess proposed initiatives: it does not consider impact assessments for initiatives that have already been implemented. Of course, developing such a methodology is a complicated undertaking and will require more work and discussion. Comments on the study would be most welcome.

39. In designing a methodology for impact assessments, there are at least two distinct approaches. The first approach is to develop a self-standing methodology for human rights impact assessments, just as has been done for environmental and social impact assessments. The other approach is to develop a methodology for integrating human rights into other existing types of impact assessments. The report proposes the second approach, consistent with mainstreaming human rights into all Government processes. The integration of human rights into existing impact assessments will require interdisciplinary collaboration between human rights professionals, experts in various types of impact assessment and others. The study contributes to this process by providing some human rights considerations and frameworks and by outlining a methodology.

40. The report presents a methodology in two parts. The first part sets out seven general principles for performing a rights-based impact assessment. These are: (a) to use an explicit human rights framework; (b) to aim for progressive realization of human rights; (c) to promote equality and non-discrimination in process and policy; (d) to ensure meaningful participation by all stakeholders; (e) to provide information and protect the right to freely express ideas; (f) to establish mechanisms to hold the State accountable; and (g) to recognize the interdependence of all human rights.

41. The second part of the methodology proposes six steps for integrating the right to health, as a starting point for integrating all human rights, into existing impact assessments. The steps are: (a) to perform a preliminary check on the proposed

[13] Some human rights assessments focus on non-governmental actors; for example, see the recent study on impact assessments and business (A/HRC/4/74).

policy to determine whether or not a full-scale right-to-health impact assessment is necessary; (b) to prepare an assessment plan and distribute information on the policy and the plan to all stakeholders; (c) to collect information on potential right-to-health impacts of the proposed policy; (d) to prepare a draft report comparing the potential impacts with the State's legal obligations arising from the right to health; (e) to distribute the draft report and engage stakeholders in evaluating the options; and (f) to prepare the final report detailing the final decision, the rationale for the choices made and a framework for implementation and evaluation.

42. Follow-up activities are proposed in the final section of the report. The Special Rapporteur is promoting the study during his country missions and it has already been presented at some workshops. Subject to further funding, it would also be helpful to distribute the report more widely for discussion. Later in 2007, the Special Rapporteur will present the report at the eighth International Health Impact Assessment Conference.

43. Further work is required to determine whether mainstreaming human rights, such as the right to health, into other existing impact assessments is feasible, including case studies with different types of impact assessments. The practical tools, such as checklists, interview guidelines and charts for connecting impacts to human rights obligations (all of which are found in the report), also need further development. There is a need to encourage Governments and impact assessment professionals to follow rights-based approaches to impact assessment and policymaking.

44. In conclusion, human rights impact assessments are an aid to equitable, inclusive, robust and sustainable policymaking. They are one way of ensuring that the right to health, especially of marginalized groups, including the poor, is given due weight in all national and international policymaking processes. From the right-to-health perspective, an impact assessment methodology is a key feature of a health system. Without such a methodology, a Government cannot know whether its proposed policies, programmes and projects are on target to progressively realize the right to the highest attainable standard of health, as required by international human rights law.

IV. Water, sanitation and the right to the highest attainable standard of health

45. The health of populations, communities and individuals requires more than medical care. Equally important are the social, cultural, economic, political and other conditions that make people need medical care in the first place.[14] A WHO commission is currently studying the social determinants of health, such as gender, poverty and social exclusion.[15] Other determinants of health include access to water, sanitation, nutrition, housing and education.

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[14] See preamble to the Constitution of the World Health Organization and R. Beaglehole, "Overview and framework", in Roger Detels, ed., *Oxford Textbook of Public Health* (Oxford University Press, fourth edition, 2002).

[15] Information about the Commission can be found on the WHO website at www.who.int/social_determinants/en/.

46. In some quarters, the right to the highest attainable standard of health is narrowly understood to mean a right to medical care. However, this view is inconsistent with international human rights law, which encompasses both medicine and public health. The International Covenant on Economic, Social and Cultural Rights, for example, and the Convention on the Rights of the Child clearly affirm that the right to health is more than access to medical care. Specifically, article 24 of the Convention on the Rights of the Child states that the right to health includes access to nutritious food, clean drinking water, environmental sanitation and so on, as well as medical care. Equating the right to health with a right to medical care is a misinterpretation of international human rights law.

47. The right to the highest attainable standard of health is an inclusive right extending not only to timely and appropriate medical care but also to the underlying determinants of health, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination.[16] In short, the right to health includes both medical care and the underlying determinants of health.

48. In his reports, the Special Rapporteur has consistently looked at medical care and the underlying determinants of health, including the impact of poverty and discrimination on health. However, he has noticed a definite tendency in some Governments, international organizations and elsewhere to devote a disproportionate amount of attention and resources to medical care at the expense of the underlying determinants of health. This is deeply regrettable because both are fundamental elements of the right to the highest attainable standard of health.

49. Although space constraints do not permit a detailed examination of all relevant issues, the present section focuses on two underlying determinants of health: access to safe water and adequate sanitation.[17] It adopts the right-to-health analytical framework that the Special Rapporteur has used in previous reports in relation to other health issues. Although confined to only two essential conditions of health, namely water and sanitation, the analysis is illustrative and relevant to other underlying determinants of health.

Water, sanitation and human rights

Water, sanitation and the right to health

50. Safe water and adequate sanitation are two integral and closely related underlying determinants which are essential for the realization of the right to the highest attainable standard of health. Inadequate access to water and sanitation can threaten life, devastate health, destroy opportunities, undermine human dignity and cause deprivation.[18]

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[16] E/2001/22-E/C.12/2000/21, annex IV, general comment 14, para. 11.

[17] In this regard, similar but different terms are sometimes used, such as “safe and potable water and adequate sanitation” and “safe drinking water and basic sanitation”. For the purposes of the present section, “safe water and adequate sanitation” is used for the underlying health determinants of water and sanitation.

[18] See UNDP, *Human Development Report 2006* (http://hdr.undp.org/hdr2006/report.cfm).

51. It is estimated that 1.8 million people die each year from diarrhoeal diseases, including cholera; 90 per cent of these are children under 5 years of age, mostly in developing countries. According to WHO, 88 per cent of diarrhoeal disease is caused by unsafe water and inadequate sanitation. Improved water supply could reduce diarrhoea morbidity by up to 25 per cent, while improved sanitation could reduce it by 32 per cent.[19]

52. Approximately 1.3 million people die of malaria each year; 90 per cent of these are children under 5 years of age. Irrigation, dams and other water-related projects are primary contributors to this disease. Better management of water resources would reduce transmission of malaria and other vector-borne diseases.[19]

53. Similarly, 160 million people are infected with schistosomiasis, a disease causing tens of thousands of deaths every year, mainly in sub-Saharan Africa. The disease is strongly related to unsanitary excreta disposal and the absence of nearby sources of safe water. Basic sanitation could reduce the disease by up to 77 per cent.[19]

54. Some 6 million people worldwide are blind because of trachoma and more than 150 million people are in need of treatment. Improving access to safe water sources and better hygiene can reduce trachoma morbidity by 27 per cent.[19]

55. Access to safe water and adequate sanitation is crucial in the context of HIV/AIDS. In relation to HIV/AIDS, as with other medical conditions, water is needed for taking medication, bathing patients, washing soiled clothing and for essential hygiene that reduces exposure to infections. When children born to women living with HIV are ensured uninterrupted access to nutritionally adequate breast-milk substitutes that are prepared using safe water, they are at less risk of illness and death.[20] As the former Secretary-General Kofi Annan observed: "We shall not finally defeat AIDS, tuberculosis, malaria, or any other infectious diseases that plague the developing world until we have won the battle for safe drinking water, sanitation and basic health care."[21]

56. In the United Nations Millennium Declaration and the Plan of Implementation of the World Summit on Sustainable Development, the international community recognized the relationship between poverty, water, sanitation, health and human development by including water supply, sanitation and hygiene in the Millennium Development Goals. Target 10 of the goals is to halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation. However, according to the WHO/UNICEF Joint Monitoring Programme, on current trends the world will miss the sanitation target by more than half a billion people. Also, although the world as a whole is on track to achieve the drinking water target, the trend appears to be deteriorating.[22]

57. Achieving the target on water and sanitation would bring substantial economic benefits. According to a recent WHO study, each dollar invested would yield an economic return of between $3 and $34, depending upon the region. If the target for water and sanitation were met, the health-related costs avoided would reach

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[19] See www.iwho.int/water_sanitation_health/publications/facts2004/en.

[20] UNAIDS/UNICEF/WHO, *HIV and Infant Feeding: Guidelines for Decision Makers*, 1998.

[21] Statement made by Kofi Annan to the fifty-fourth World Health Assembly, Geneva, 17 May 2001.

[22] WHO/UNICEF, *Meeting the Millennium Development Goal Global Water and Sanitation Target: the Urban and Rural Challenge of the Decade* (2006).

$7.3 billion per year.[23] In other words, an improvement in water and sanitation is an investment that not only saves lives and enhances health, but also generates huge savings for both national health budgets and households.[24]

Water, sanitation and other human rights

58. In addition to the right to the highest attainable standard of health, water and sanitation contribute to the realization of several other economic, social and cultural rights.

59. In the context of the right to adequate food, for example, the Committee on Economic, Social and Cultural Rights has emphasized the importance of ensuring sustainable access to water for agriculture.[25] The Special Rapporteur on the right to food has also underscored the interdependence of water and the right to food, observing that clean drinking water is an essential part of healthy nutrition.[26] At the regional level, as part of the right to food security, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa requires States to ensure women's access to clean drinking water.

60. Both the Committee on Economic, Social and Cultural Rights and the Special Rapporteur on the right to education have emphasized that schools should have a supply of drinking water, as well as separate, private and safe sanitation facilities for girls.[27]

61. Sustainable access to safe water and adequate sanitation also constitutes a fundamental element of the right to adequate housing.[28] Principle 2 of the Programme of Action of the International Conference on Population and Development (Cairo, 1994) recognizes that all individuals have the right to an adequate standard of living for themselves and their families, including adequate water and sanitation (see A/CONF.171/13, chap. I, resolution 1, annex). Moreover, access to water and sanitation is a key element of the mandate of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and the Special Rapporteur on housing emphasizes that inadequate access to water is particularly devastating for women and children.[29]

62. In short, access to water and sanitation is integral to several human rights, including the right to the highest attainable standard of health.

Water and sanitation as a human right

63. The human right to water and sanitation is recognized as a self-standing right in a wide range of international documents, including treaties and declarations, as

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[23] B. Evans et al., *Closing the Sanitation Gap: the Case for Better Public Funding of Sanitation and Hygiene* (OECD, 2004).

[24] J. Bartram et al., *Focusing on improved water and sanitation for health, Lancet*, vol. 365 (2005).

[25] E/2000/22-E/C.12/1999/11, annex V, general comment 12, paras. 12 and 13.

[26] A/56/210, paras. 58-71; see also E/CN.4/2003/54.

[27] E/CN.4/2006/45, para. 129.

[28] E/1992/23-E/C.12/1991/4, annex III, general comment 4, para. 8.

[29] See E/CN.4/2003/5 and E/CN.4/2002/59.

well as by governmental and non-governmental bodies and in various court decisions.[30]

64. While the International Covenant on Economic, Social and Cultural Rights makes no explicit reference to the right to water and sanitation, the Committee on Economic, Social and Cultural Rights takes the view that water is an independent right implicit in the Covenant and closely related to the rights to the highest attainable standard of health, adequate housing and food.

65. The Committee defines the right to water as the right of everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic use.[31] It specifies that access to adequate sanitation constitutes one of the principal mechanisms for protecting the quality of drinking water and that States should progressively extend safe sanitation services to rural and deprived urban areas.[32] In its elaboration of the normative content of the right to water and the legal obligations that arise from it, the Committee notes that, during armed conflicts, emergency situations and natural disasters, the obligations of States encompass the right to water, as well as those provisions of international humanitarian law relating to water.[33]

66. For its part, in its resolution 2006/10, the Subcommission on the Promotion and Protection of Human Rights confirms the right to sufficient supplies of water to meet essential needs, as well as access to acceptable sanitation facilities that take account of the requirements of hygiene, human dignity, public health and environmental protection (see A/HRC/2/2, chap. II).

67. At the regional level, the right to a sufficient quantity of water to meet basic needs is recognized by the Council of Europe in paragraphs 5 and 9 of its recommendation 14 on the European Charter on Water Resources (2001). Similarly, at their recent summit, the Heads of State or Government of the Non-Aligned Movement acknowledged the right to water for all in their final document.

68. At the national level, the constitutions of certain countries (for example, South Africa and Uruguay) incorporate an explicit right to water. Moreover, a number of judicial decisions rely upon this human right. For instance, in the case of *Residents of Bon Vista Mansions v. Southern Metropolitan Local Council*, the South African High Court found that disconnecting a water supply represented a prima facie breach of the State's constitutional duty to respect the right to water. Similarly, in *Subhash Kumar v. State of Bihar*, the Indian Supreme Court held that the right to life was a fundamental right under Article 21 of the Constitution, and it included the right of enjoyment of pollution-free water and air for full enjoyment of life.

69. The *Human Development Report 2006* underscores the importance of adopting a rights-based approach to the provision of safe water and adequate sanitation, and emphasizes that access to water is a basic human need as well as a fundamental human right. According to the report, the right to water corresponds to a secure,

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[30] See WHO, OHCHR, the Centre on Housing Rights and Evictions, *Water Aid* and the Center for Economic and Social Rights, *The Right to Water* (2003) (www.who.int/water_sanitation_health/rtwrev.pdf).

[31] E/2003/22-E/C.12/2002/13, annex IV, general comment 15, para. 2.

[32] Ibid., para. 29.

[33] Ibid., para. 22.

accessible and affordable water supply.[34] The report emphasizes the responsibility of governments to recognize the right to water in enabling legislation and to work towards its progressive realization.

Right-to-health analytical framework

70. In recent years, the Committee on Economic, Social and Cultural Rights, WHO, civil society organizations, academics and many others have developed a way of "unpacking" or analysing the right to health with a view to making it easier to understand and apply in practice to health-related policies, programmes and projects. For his part, the Special Rapporteur has tried to apply and refine this analytical framework in his country and other reports.[35] Importantly, however, the framework has general application to all aspects of the right to the highest attainable standard of health, including the underlying determinants of health, such as safe water and adequate sanitation.

71. While the analytical framework is discussed in detail elsewhere,[36] its key elements may be very briefly summarized as follows:

(a) Identification of the relevant national and international human rights laws, norms and standards;

(b) Recognition that the right to health is subject to resource constraints and progressive realization, requiring the identification of indicators and benchmarks to measure progress (or the lack of it) over time;

(c) Nonetheless, recognition that the right to health imposes some obligations that are subject to neither resource constraints nor progressive realization, but are of immediate effect, for example, the obligation to avoid discrimination;

(d) Recognition that the right to health includes freedoms (for example, freedom from discriminatory access to water) and entitlements (such as the provision of minimum essential levels of water and sanitation). For the most part, freedoms do not have budgetary implications, while entitlements do;

(e) All health services, goods and facilities shall be available, accessible, acceptable and of good quality (this scheme is briefly applied to water and sanitation in the context of the right to health in paras. 73 to 76 below);

(f) States have duties to respect, protect and fulfil the right to the highest attainable standard of health (this, too, will be briefly applied to water and sanitation in the context of the right to health in paras. 82 and 83 below);

(g) Because of their crucial importance, the analytical framework demands that special attention be given to issues of non-discrimination, equality and vulnerability;

(h) The right to health requires that there be an opportunity for the active and informed participation of individuals and communities in decision-making that has a bearing on their health;

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[34] See UNDP, *Human Development Report 2006*.

[35] For example, see A/61/338; see also E/CN.4/2006/48/Add.2.

[36] See E/CN.4/2005/51.

(i) Developing countries have a responsibility to seek international assistance and cooperation, while developed States have some responsibilities towards the realization of the right to health in developing countries;

(j) The right to health requires that there be effective, transparent and accessible monitoring and accountability mechanisms available at the national and international levels.

72. By way of illustration, the present section will briefly apply elements of this framework to water and sanitation in the context of the right to health.

Responsibilities of States

Available, accessible, acceptable and quality

73. The right to health requires a State to do all it can to ensure safe water and adequate sanitation is available to everyone in its jurisdiction. The quantity of water available for each person should correspond to the quantity specified by WHO.[37] Some individuals and groups may require additional water owing to health, climate and work conditions, and the State should therefore ensure that water is available in sufficient quantities to fulfil the needs of such groups and individuals. States should take measures against overconsumption and to ensure efficient water use. The right to health requires States to ensure that safe water is available for personal and domestic uses such as drinking, personal sanitation, washing of clothes, food preparation, personal and household hygiene.[38]

74. In addition to being available, the right to health requires that water and sanitation also be accessible to everyone without discrimination. In the context of water and sanitation, access has four dimensions:

(a) Water and sanitation must be within safe physical reach for all sections of the population, in all parts of the country. Water and sanitation therefore should be physically accessible within, or in the immediate vicinity of, the household, educational institution, workplace and health or other institution.[39] The inaccessibility of water within safe physical reach can seriously impair health, especially of women and children responsible for carrying water. Carrying heavy water containers for long distances can cause fatigue, pain and spinal and pelvic injuries, which may lead to problems during pregnancy and childbirth. Similarly, the absence of safe, private sanitation facilities subjects women to a humiliating, stressful and uncomfortable daily routine that can damage their health.[40] When designing water and sanitation facilities for refugee camps and those for internally displaced persons, special attention should be given to prevent gender-based violence. For example, facilities should be provided in safe areas near dwellings;[41]

(b) Water and sanitation must be economically accessible (that is, affordable), including to those living in poverty. Poverty is associated with inequitable access to health services, safe water and sanitation. If those living in

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[37] See G. Howard and J. Bartram, *Domestic Water Quantity, Service Level and Health* (WHO, 2002).

[38] E/2003/22-E/C.12/2002/13, annex IV, general comment 15, para. 12 (a).

[39] E/CN.4/Sub.2/2005/25, guideline 1.3.

[40] See United Nations Millennium Project Task Force on Water and Sanitation, *Health, Dignity and Development: What Will it Take?* (2005).

[41] See UNHCR, *Access to Water in Refugee Situations* (2005).

poverty are not enjoying access to safe water and adequate sanitation, the State has a duty to take reasonable measures that ensure access to all;

(c) Water and sanitation must be accessible to all without discrimination on any of the prohibited grounds, such as sex, race, ethnicity, disability and socio-economic status;

(d) Reliable information about water and sanitation must be accessible to all so that they can make well-informed decisions.

75. As well as being available and accessible, the right to health requires that water and sanitation facilities be respectful of gender and life-cycle requirements and be culturally acceptable. For example, measures should ensure that sanitation facilities are mindful of the privacy of women, men and children.

76. The right to health requires that water services and sanitation facilities be of good quality. Water required for personal and domestic use should be safe and free from micro-organisms, chemical substances and radiological hazards which constitute a threat to a person's health.[42] States should establish water quality regulations and standards on the basis of the WHO Guidelines for drinking water quality.[43] Similarly, sanitation facilities should be of adequate quality. Each person should have affordable access to sanitation services, facilities and installations that are adequate for the promotion and protection of human health and dignity. Good health requires the protection of the environment from human waste; this can only be achieved if everyone has access to, and utilizes, adequate sanitation.[44] Good quality water and sanitation reduce susceptibility to anaemia and other conditions that cause maternal and infant mortality and morbidity.

Combating discrimination, inequality and vulnerability

77. Arising out of the concepts of non-discrimination and equality, international human rights law has a preoccupation with vulnerability and disadvantage. This requires a State to take measures in favour of disadvantaged communities and individuals. In the present context, non-discrimination and equality have numerous implications. For example, they require a State to establish a national water and sanitation policy that is mindful of national and local health priorities and includes policies and programmes that address the needs of the disadvantaged. Non-discrimination and equality also require a State to give attention to individuals and groups who have special water and sanitation needs owing to health, climate or other conditions.

78. The right to health therefore requires a State to design a national water and sanitation policy aimed at ensuring equitable access for vulnerable and disadvantaged individuals and groups, including women and children, ethnic minority and indigenous populations, persons living in poverty, persons living with HIV/AIDS, internally displaced persons, the elderly, persons with disabilities, prisoners and others.

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[42] E/2003/22-E/C.12/2002/13, annex IV, general comment 15, para. 12 (b).

[43] WHO, "Guidelines for drinking water quality" (2006).

[44] See E/CN.4/Sub.2/2004/20, para. 44.

Progressive realization and the obligations of immediate effect

79. The right to the highest attainable standard of health — and thus the underlying determinants of health, such as safe water and adequate sanitation — are subject to progressive realization and resource availability, in accordance with article 2, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights. Put simply, progressive realization means that a State is required to be doing better in two years time than it is doing today, while resource availability means that what is required of a developed State is of a higher standard than what is required of a developing State.

80. This has a number of important implications. For example, States need appropriate indicators and benchmarks so they know whether or not they are progressively realizing the right to health (see human rights-based approach to health indicators set out in document E/CN.4/2006/48). But it also has an important qualification: the right to health includes some core obligations of immediate effect that are not subject to progressive realization.[45] These are obligations without which it is considered that the right would be deprived of its raison d'être.[46] Under the right to health, for example, States have an immediate obligation to avoid discrimination and ensure access to basic sanitation,[47] as well as the minimum essential amount of water that is sufficient and safe for personal and domestic uses to prevent disease.[48]

81. In summary, while the State is required to progressively realize access to water and sanitation, it has a core obligation of immediate effect to make available and accessible the minimum essential amount of water that is sufficient and safe for personal and domestic uses, and basic sanitation,[49] throughout its jurisdiction. Retrogressive measures, which reduce people's access to water and sanitation, are only allowed when a State is able to demonstrate that such measures have been adopted after full consideration of alternatives and are "duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources".[50]

Duties to respect, protect and fulfil

82. States have duties to respect, protect and fulfil the right to the highest attainable standard of health. These duties are equally applicable to medical care and the underlying determinants of health. For example, in the context of the underlying determinants of safe water and adequate sanitation, the duty to respect obliges the State to refrain from polluting water or arbitrarily interfering with a person's access to water and sanitation. The duty to protect obliges the State to take

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[45] E/2001/22-E/C.12/2000/21, annex IV, general comment 14, para. 43.

[46] E/1991/23-E/C.12/1990/8 and Corr.1, annex III, general comment 3, para. 10.

[47] E/2001/22-E/C.12/2000/21, annex IV, general comment 14, para. 36.

[48] There is a difference between the water core obligation in general comment 14, para. 36 and general comment 15, para. 37 (a). Here, the more modest of the two is used, i.e. general comment 15, para. 37 (a).

[49] Basic sanitation is defined by the United Nations Task Force on Water and Sanitation as "the lowest-cost option for securing sustainable access to safe, hygienic and convenient facilities and services for excreta and sullage disposal that provide privacy and dignity, while at the same time ensuring a clean and healthful living environment both at home and in the neighbourhood of users".

[50] E/2001/22-E/C.12/2000/21, annex IV, general comment 14, para. 32.

effective measures to stop third parties from interfering with access to water and sanitation. For example, a State must take effective steps to ensure that private service providers do not compromise access to safe water and adequate sanitation. The duty to fulfil requires a State to provide those living in poverty with the minimum essential amount of water and basic sanitation if they would otherwise be unable to access them.

83. In other words, whether the supply of water and sanitation facilities is entrusted to a public or a private company, a State remains responsible for the proper regulation of its water and sanitation systems, as well as for the health and well-being of the most disadvantaged in its jurisdiction.

Participation

84. The active and informed participation of individuals and communities in health policymaking that affects them is an important feature of the right to the highest attainable standard of health. The right requires that special efforts be made to ensure the participation of individuals and groups that have traditionally been excluded or marginalized. For instance, in the context of water and sanitation, even though women bear a disproportionate burden in the collection of water and disposal of family wastewater, they are often excluded from relevant decision-making processes. States should therefore take measures to ensure that women are not excluded from decision-making processes concerning water and sanitation management.

85. In most cases, communities and groups have a better sense of the kind of water and sanitation services they require and how those services should be managed. Therefore, when formulating its national water and sanitation policy and programmes, a State should take steps to ensure the active and informed participation of all those likely to be affected.

International assistance and cooperation

86. States have the obligation to take steps individually and through international assistance and cooperation towards the full realization of various rights, including the right to health. Depending upon the availability of resources, developed countries should provide financial and technical assistance to supplement the resources of developing countries with a view to ensuring that everyone has access, as promptly as possible, to safe water and adequate sanitation.

87. Given the massive public health challenge posed by the inadequacy of water and sanitation facilities in the developing world, the Special Rapporteur reminds States of the commitments made under the Millennium Declaration and the World Summit on Sustainable Development and emphasizes the need for a global partnership on water and sanitation, aimed at establishing an effective, integrated water and sanitation supply system delivering quality affordable water and sanitation for all.

Monitoring and accountability

88. The right to health brings with it the crucial requirement of accessible, transparent and effective mechanisms of monitoring and accountability. Those with right-to-health responsibilities must be held to account in relation to the discharge of

their duties, with a view to identifying successes and difficulties; so far as necessary, policy and other adjustments can then be made. There are many different forms of monitoring and accountability mechanisms: judicial, quasi-judicial, administrative and political. While a State will decide which are most appropriate in its particular case, all mechanisms must be effective, accessible and transparent.

89. A national water and sanitation policy must be subject to appropriate monitoring and accountability. This requires that the policy set out the Government's right-to-health obligations in relation to water and sanitation, as well as an implementation plan that identifies objectives, timelines, duty holders and their responsibilities, indicators, benchmarks and reporting procedures. From time to time, a suitable national body (such as a health ombudsperson or a water and sanitation regulator) will have to consider the degree to which those responsible for the implementation of the national water and sanitation policy have fulfilled their duties — not necessarily with a view to sanction and punishment, but with a view to establishing which policies and institutions are working and which are not, with the aim of enhancing access to water and sanitation for all.

Some key issues

90. Ensuring access to water and sanitation for all gives rise to a wide range of specific, practical and important issues. By way of illustration, the present section briefly introduces some of these issues, keeping in mind the analytical framework signalled in preceding paragraphs.

Water privatization

91. In some quarters, privatization has been promoted as a way of responding to the global water crisis and ensuring access to all. However, experience shows that privatization may lead to price increases that do not take into account the ability of lower-income consumers to pay. For example, it is estimated that, after privatization, residents of Cochabamba in Bolivia were spending more than 25 per cent of their average household income on water, leading to violent protests in early 2000.[51] Similarly, privatization in the Philippines led to a 60 to 65 per cent increase in water tariffs, which meant that many people could not afford to pay them.[52]

92. The high cost of water may force households to use alternative sources of water of poorer quality that are a greater risk to health. Furthermore, the high cost of water may reduce the volume of water used by households to such an extent that hygiene and health are compromised.[53]

93. While international human rights law does not demand a particular form of service delivery or pricing policy, States must ensure that private water and sanitation providers do not compromise access to affordable, physically accessible water and sanitation.[54] Whether the supply of water and sanitation facilities is

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[51] G. Dalton, *Private Sector Finance for Water Sector Infrastructure: What Does Cochabamba Tell Us About Using This Instrument, Occasional Paper*, No. 37 (University of London School of Oriental and African Studies, 2001).

[52] Marites Sison, "Philippines: awash in water bills after privatization", Inter Press Service, 22 January 2003.

[53] See WHO, loc. cit.

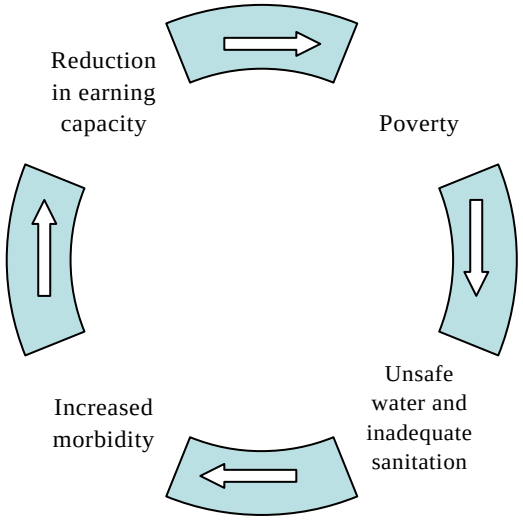
[54] See E/CN.4/2004/49/Add.1, para. 11.

entrusted to a public or private company, the State has an obligation to put an effective regulatory system in place to ensure, inter alia, that those living in poverty receive a minimum supply of drinking water and basic sanitation.[55]

Three key obstacles

1. Poverty

94. The poor and other marginalized groups have the greatest difficulty in gaining access to safe water and adequate sanitation. Many poor people living in slums, informal settlements and rural communities have no water connection, so they use water from unsafe sources and have inadequate sanitation, resulting in increased levels of morbidity and mortality.



95. An increase in morbidity leads to a reduction in earning capacity, creating a vicious cycle of poverty and ill health that is devastating among the poorest (see figure above). Poverty renders women and men ill-equipped to protect themselves and their children from diseases or to seek treatment for illness. Poor health and an impaired ability to work, compounded by high health costs, deepens poverty.

96. Enhancing access to safe water and adequate sanitation is not only critical to reducing morbidity and mortality; it is also a vital strategy in the struggle against poverty.

2. Gender inequality

97. The relationship between poverty and gender inequality is well known. The traditional roles and tasks assigned to women, such as securing water for household needs, caring for children, the elderly and ill, mean that women are often unable to attend educational institutions and are denied labour opportunities, which may lead to impoverishment and poor health. In some societies, women are further burdened with the task of disposing of the family's wastewater and faeces, exposing them to

[55] E/2003/22-E/C.12/2002/13, general comment 15, para. 24.

severe health hazards. Thus, women are hit hardest by the inadequate availability of water and sanitation services.

98. The water and sanitation needs of women are different from those of men. For example, women tend to place a higher value on household toilets than men, yet women are often absent from decision-making and priority-setting processes. The result is that the distinctive water and sanitation needs of women and girls (for example during menstruation and during and after pregnancy) are often neglected in discussions about sanitation and hygiene.

99. Inadequate water supply and sanitation services severely prejudices the health, productivity, income-generating capacity, physical security and dignity of women living in poverty. The Special Rapporteur emphasizes the need to ensure women's participation in decision-making and priority-setting processes, and urges States to adopt a gender-sensitive approach in all relevant policymaking. Moreover, involving women in decision-making will lead to positive health benefits for the entire community.

3. Global warming

100. Those living in poverty are disproportionately affected by the adverse effects of global warming. Not only has global warming led to a decline in dependable access to water, it has also led to a disruption in natural ecosystems. Warmer and wetter conditions resulting from climate change are increasing the range and season of vectors, such as mosquitoes and tsetse flies, which spread diseases such as malaria, dengue and yellow fever, and encephalitis.[56]

101. Global warming will adversely affect the world's hydrological cycle and result in more droughts and floods. Drought poses serious threats to health.[57] As clean water sources evaporate, people resort to more polluted alternatives that may lead to epidemics of water-borne diseases. Likewise, floods not only increase the risk of drowning and destroying crops, they also spread disease by extending the range of vectors and by washing agricultural pollutants into drinking water supplies.[57]

102. Despite these disturbing trends, the international community has not yet confronted the health threats posed by global warming. The failure of the international community to take the health impact of global warming seriously will endanger the lives of millions of people across the world.

V. Conclusions and Recommendations

103. **The conclusions and recommendations set out below focus on section IV.**

104. **The right to the highest attainable standard of health not only encompasses medical care but also underlying determinants of health, such as safe water, adequate sanitation, healthy occupational and environmental conditions, and freedom from discrimination. Too often, a disproportionate amount of attention is devoted to medical care, at the expense of the underlying determinants of health.**

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[56] McMichael and others, "Climate change and human health" (WHO/UNEP/WMO, 2003).

[57] New Economics Foundation, *The End of Development* (2006).

105. **While the present report gives particular attention to water and sanitation, it must be understood that the right to health encompasses numerous other underlying determinants. The analytical framework set out in the report can be applied to other underlying determinants of health.**

106. **Although fundamental to survival, development, economic growth and the right to health, water and sanitation are frequently neglected. Many States devote inadequate budgetary resources to water and sanitation and fail to develop adequate plans, policies, programmes and laws. Historically, international organizations have neglected water and sanitation, although WHO and OHCHR are both taking important strides towards redressing this imbalance. Also, donors have inadequately supported safe water and adequate sanitation initiatives, although there are some signs that this is beginning to change. Civil society organizations have made commendable progress in advancing debates on issues of water, sanitation and human rights.**[58]

107. **In order to redress this neglect, the Special Rapporteur makes the following recommendations:**

(a) ***Formal recognition*. All States should formally recognize that the right to the highest attainable standard of health includes access to safe water and adequate sanitation;**

(b) ***Laws, plans, policies, programmes and projects*. By way of participatory processes, States should formulate and implement laws, plans, policies, programmes and projects that enhance access to safe water and adequate sanitation for all;**

(c) ***National budgets and international assistance*. The vital importance of safe water and adequate sanitation to health — and the right to health — must be reflected in national budgets and international assistance and cooperation;**

(d) ***Disadvantaged groups and individuals*. Consistent with international human rights law, measures (both national and international) to enhance access to safe water and adequate sanitation must give particular attention to disadvantaged groups and individuals, such as the poor, as well as those living in rural communities and urban informal settlements, irrespective of their tenure status;**

(e) ***Gender*. In the context of water, sanitation and the right to health, it is extremely important that States, international organizations and others adopt a gender-sensitive approach to all relevant policymaking;**

(f) ***An integrated approach*. The right to the highest attainable standard of health requires an integrated approach whereby adequate sanitation and hygiene are included in water supply programmes;**

(g) ***Public information campaigns*. Large-scale public awareness health campaigns are needed to provide information relating to water and sanitation, for example on hygiene, safe water storage and monitoring water quality. This**

[58] See, for example, the Right to Water Programme, Centre for Housing Rights and Evictions (www.cohre.org); Water Law Research Programme (www.ielrc.org); and Water Aid (www.wateraid.org).

is particularly important for low-income households that rely on small-scale water and sanitation facilities;

(h) ***International Year of Sanitation (2008)*. The General Assembly recently declared 2008 the International Year of Sanitation to raise awareness about the importance of sanitation.[59] The Special Rapporteur urges States to seize this opportunity to take joint and concerted efforts towards the realization of the Millennium Development Goal water and sanitation target;**

(i) ***Monitoring and accountability*. One of the most important steps which many States need to take towards realization of the right to health generally, and access to water and sanitation in particular, is to establish an effective, transparent and accessible monitoring and accountability mechanism. This may be, for example, a national human rights institution, health ombudsperson or water and sanitation regulator. The mechanism should have the responsibility to monitor and hold all relevant public and private actors to account, in relation to the national water and sanitation policy, as well as access to water and sanitation for all;**

(j) ***Climate change*. The Special Rapporteur calls on the Human Rights Council to urgently study the impact of climate change on human rights generally and the right to the highest attainable standard of health in particular;**

(k) ***The human right to water and sanitation*. To its credit, the Human Rights Council has begun to study the issue of human rights and access to water.[60] It is recommended that the Council appoint a special rapporteur on the right to water and sanitation to assist States understand their legal obligations, identify and disseminate best practices and monitor the progressive realization of this important human right. For their part, all States should recognize the human right to water and sanitation.**

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[59] General Assembly resolution 61/192.

[60] See A/HRC/L.3/Rev.3.