VIEWPOINT

# Challenges in Promoting the Interdependence of all Human Rights

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I am taking the opportunity presented by this series of reflections on the right to health to comment on my experiences as the UN Special Rapporteur on the right to health, especially as I am now entering the final year of this mandate.

Our understanding of the meaning of the right to health was greatly helped in the year 2000 by General Comment 14, and its resulting analytical framework. This has assisted States to understand their legal obligations regarding the right to health, and accordingly, over the past five years I have seen a lot of progress, globally, and in certain countries as states have invested in healthcare services and attempted to make these services available, accessible, acceptable, and of good quality. During my 11 official country missions to date, covering all geographical regions, I have observed many good efforts to balance an investment in primary care with hospital care. But I have also had to remind many other states, even when they are enthusiastic about reaching universal health coverage, that primary healthcare is of crucial importance. Furthermore, primary healthcare extends considerably further than simply ensuring, for example, that essential medicines and vaccines are available; it also demands that there are adequate standards of sexual and reproductive healthcare, mental healthcare, and palliative care.

Health-related policies need to ensure that costly diagnostic and therapeutic biomedical interventions are not prioritized at the expense of strengthening primary healthcare which is the key to reaching everyone and leaving no one behind. Users and providers of healthcare services, especially medical doctors, as well as politicians and the general public, need to understand that money spent addressing the determinants of health is the most effective investment in health and healthcare.

Various incentives from those with vested interests have influenced medical education, as well as decision makers and the general public, to see healthcare predominantly as a field of biomedicine. I respond to this very limited perspective of healthcare by reminding all stakeholders that:

- medicine is a social science
- "do no harm" is a primary principle
- primary care, community health, and preventive medicine should be prioritized over specialized medicine.

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The right to health cannot be exercised effectively if other human rights are undermined. During my numerous debates with stakeholders I have often observed their reluctance to accept this broad approach in health. Instead, they prefer to narrowly focus only on healthcare itself. For example, during my country missions I have expressed my wish to visit not only hospitals and other healthcare facilities, but also migrant detention centers, prisons, long-term social care institutions, and other places where people are deprived of liberty. I have also visited places where people live, grow, work, including in disadvantaged communities, schools, and workplaces. This reflects my view that the right to health is not just about entitlements, but it is also about freedoms. Even though the right to health is an economic, social and cultural right, it is very important to acknowledge that people's right to health entitlements cannot be exercised effectively if their civil and political rights are undermined, and if space for civil society is shrinking.

In the current political economy, human rights are often used selectively. It is crucial to counteract this by stressing the indivisibility and interconnectedness of all human rights. We are witnessing rising populism and nationalism in many countries. This can result in a combination of some improvement in social and economic rights (addressing poverty, providing better healthcare), and at the same time shrinking space for civil society, and restricting civil and political rights and freedoms. In my missions to countries and in reports, I have warned that such a selective approach to human rights will not be helpful in achieving the Sustainable Development Goals (SDGs), including Goal 3 (ensure healthy lives and promote wellbeing for all at all stages). To fully achieve this goal, people need to be empowered to take control and ownership of their lives and their health, which also requires democracy and space for civil society. Realization of the right to physical and mental health is absolutely dependent on realization of all human rights.

I can illustrate this interdependence of rights with two important issues: the right to health in childhood, and the right to mental health.

## Illustration of child health and development

There has been a high level of political commitment over the past few decades to reduce the mortality of infants and children under five years of age. The question I have raised frequently, including in thematic reports and in country missions, is why the global community still often considers that the rights of children to holistic development, including emotional and social development, is not as important as the right to life and survival. Article 6 of the Convention of the Rights of the Child is about the right to life, survival, and development. It is not wise to limit investment to just the prevention of child mortality and not support development. If the global community ignores the need to support the healthy development of children, it should not be surprised to witness subsequent high levels of all forms of violence, which will further threaten the attainment of the SDGs.

The best way to prevent threats to peace and security and to achieve sustainable development is to protect children, starting in early childhood, from adverse childhood experiences including all forms of violence. There are well known cost-effective interventions that promote healthy emotional and social development, including investment in parenting competencies, and protecting children and women from violence in families and communities. Investing in such interventions should not be seen as an optional add-on. These interventions are the equivalent to vaccination; they are essential to prevent many new "morbidities", just as infectious diseases are prevented with vaccines. Essential interventions in the health sector should not stop at biomedical interventions; they should include essential psychosocial and public health interventions.

## Illustration of mental health

There are also opportunities and challenges for the global community when considering the best ways to invest in mental health. The good news is that mental health is finally recognized as a global health priority. There is consensus that greater

investment is needed to make mental healthcare more available and of better quality. However, there is a lack of agreement about what to invest in. Many experts are enthusiastic about the need to cover the treatment gaps, to invest more so that many more people with mental health needs, especially in low- and middle-income countries, can receive adequate treatment. And there is another group of experts that warns against further investments in the status quo and calls for a shift in the paradigm and to focus on the need to fully integrate a human rights-based approach in mental health policies and services.

My mandate supports the position of this second group. In my reports to UN Human Rights Council in 2017 and 2019 I have provided arguments to support the view that global mental health remains a hostage to the legacy of coercion, institutionalization, and overmedicalization. Should we increase investments in such systems, and recommend such systems to low-resource countries? This is another example of the failure which occurs if human rights and the right to health are addressed selectively. For example, there is a high prevalence of institutional care, coercive practices, and excessive use of biomedical interventions in mental healthcare in the high- and middle-income European region. To a large extent this is an outcome of paternalistic approaches and biomedical models that have been the main drivers of mental health practice for many decades. The prevailing focus on "fixing disorders" and providing people experiencing mental health conditions with only their basic needs (treatment, food, housing), while denying them their civil rights and freedoms, resulted in huge numbers of institutionalized and overmedicalized people in many parts of the world, including in high-income countries where funding restraints have not been the driver of such inadequate care. This type of status quo is absolutely unacceptable.

The last few decades in which the biomedical model has dominated mental healthcare, with its promise to end stigma and discrimination, have had the opposite effect. Such a reductionistic approach has failed as it has disempowered people and undermined their human rights. This scenario, when mental healthcare services are based on discriminatory laws and practices, and thus can do more harm than good, should be a sobering lesson for the global community as it deliberates on how to invest in mental health in low resource countries.

The early AIDS movement provides good lessons for the global community as it develops policies and services to address other health-related issues, such as non-communicable diseases and mental health conditions. Advances in biomedical sciences will work for good only if human rights-based approaches are seriously integrated in global and national efforts to invest effectively in the health of individuals and populations. The principles of non-discrimination, participation, empowerment, and accountability need to be applied in all health-related policies, and there should be no exceptions to the full application of these principles.