

SUBMISSION TO OHCHR

WATER AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

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INTRODUCTION

1. In his preliminary report to the Commission on Human Rights, the Special Rapporteur on the right to the highest attainable standard of health defined this human right as an inclusive right not only extending to timely and appropriate health care, but also to *the underlying determinants of health, such as access to safe and potable water and adequate sanitation*, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.¹
2. The relationship between water, health, the environment and socio-economic circumstances are complex and multidirectional. There are serious public health consequences that result from a shortfall in water quantity and quality. The health effects of such a shortfall, in particular on the most vulnerable, disadvantaged and socially excluded, can be extreme. In order to understand the scope and content of the right to water it is therefore important to understand the complex relationship between water, health, the environment and poverty.
3. In his report to the Commission on Human Rights, the Special Rapporteur commented that poverty is associated with inequitable access to both health services and the underlying determinants of health.²
4. Water and sanitation are one of the primary drivers of good health. Under the right to health, States have a legal obligation to ensure that safe and potable drinking water and adequate sanitation are available and accessible in sufficient quantity to everyone without discrimination. The right to health gives rise to an entitlement to geographically accessible safe drinking water and adequate sanitation.
5. It has been emphasized by the Special Rapporteur that the right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for

¹ Report of the Special Rapporteur to the Commission on Human Rights, E/CN.4/2003/58, 13 February 2003, para 23.

² Report of the Special Rapporteur to the Commission on Human Rights, E/CN.4/2004/49, 16 February 2004, para 14.

people to enjoy the highest attainable level of health. Unquestionably, this entitlement encompasses adequate water and sanitation.

6. In recent years, the Special Rapporteur has developed an analytical framework (based on CESCR General Comment 14) that ‘unpacks’ the right to health. He has used this framework (or aspects of it) in all his numerous general and country reports. The most comprehensive elaboration and application of this framework is in his report on mental disabilities and the right to health.³ 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 water and sanitation.
7. Presently, the authors of this submission are working on a paper that applies this right-to-health analytical framework to water and sanitation.
8. In the meantime, the following extracts from the Special Rapporteur’s existing reports (both general and country specific) set out some of the specific passages on the right to the highest attainable standard of health, water and sanitation.

EXTRACTS FROM SOME OF THE EXISTING REPORTS OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Report (A/58/427) submitted to the General Assembly on 10 October 2003

51. The Special Rapporteur’s preliminary report outlines the right to health normative framework. For present purposes, three aspects of this framework require brief mention. First, the right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. Second, the right to health should be understood as a right to the enjoyment of a variety of facilities, goods and services necessary for the realization of the highest attainable standard of health. Third, health facilities, goods and services, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality.

Report (A/60/348) submitted to the General Assembly on 12 September 2005

II. Commission on Social Determinants of Health

³ Report of the Special Rapporteur to the Commission on Human Rights, E/CN.4/2005/51, 10 February 2005. For another example, see his General Assembly report on access to medicines, A/61/338, 13 September 2006.

5. In accordance with international human rights law, realizing the right to health requires access not only to timely and appropriate health care, but also to the crucial “underlying determinants” of health. These include factors that influence health such as safe drinking water and food, adequate sanitation and housing, healthy work and environmental conditions, and so on. From the outset, the Special Rapporteur has addressed these issues throughout his mandate, including in the course of his country missions.

6. Recognizing the vital importance of the underlying determinants of health, the World Health Assembly recently established, for a three-year period, an important commission composed of leading policymakers and practitioners, in order to study the social dimensions of health. The Commission on Social Determinants of Health seeks to translate public health knowledge into actionable global and national policy agendas, in order to improve health and access to health care. Information about the Commission can be found on the WHO website at www.who.int/social_determinants/en/. In brief, the Commission’s work includes compiling and analysing scientific evidence on social mechanisms that shape health and health inequities, developing policy recommendations to strengthen health and advance health equity through action on social determinants, and advocating for implementation of recommendations in countries.

7. There is considerable congruity between the Commission’s mandate and the “underlying determinants of health” dimension of the right to health, as well as other interconnected human rights such as adequate housing, food and water. In other words, national and international human rights law informs and reinforces the Commission’s mandate. At a preliminary informal meeting with members of the Commission secretariat, the Special Rapporteur expressed his firm support for the Commission’s important and far-reaching mandate. He looks forward to further interaction and to learning how the Commission proposes to integrate the right to health into its work. If the Commission wishes, the Special Rapporteur will be pleased to provide whatever support his very limited resources permit.

Report (E/CN.4/2003/58) submitted to the Commission on Human Rights on 13 February 2003

23. *Health care and the underlying determinants of health.* The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health related education and information, including on sexual and reproductive health.

Report (E/CN.4/2006/48) submitted to the Commission on Human Rights on 3 March 2006

5. The health system must encompass both health care *and* the underlying determinants of health, such as adequate sanitation, safe drinking water and health education.

(...)

9. A health system cannot simply be understood in terms of an individual's access to doctors, medicines, safe drinking water and adequate sanitation. The social and economic conditions of the population served by a health system have a dramatic impact upon the population's health. Known as the social determinants of health, these are the conditions, such as poverty and unemployment, which may make people ill in the first place. When the Special Rapporteur talks about the underlying determinants of health, he is not referring only to determinants such as safe drinking water and adequate sanitation, but also to the social determinants of health. These determinants are presently the focus of the WHO Commission on Social Determinants of Health that the Special Rapporteur briefly highlighted in his last report to the General Assembly.

10. Fundamentally, this is what the right to health is all about: an effective, integrated, responsive health system, encompassing health care and the underlying determinants of health, accessible to all.

World Summit, September 2005

11. One of the most striking features of the Millennium Development Goals is the prominence they give to health: reducing child and maternal mortality; controlling HIV/AIDS, malaria and tuberculosis; providing access to sanitation and safe drinking water; and so on. Moreover, the first Goal - to eradicate extreme poverty and hunger - cannot conceivably be accomplished if the health Goals are not achieved. Societies burdened by large numbers of sick and dying individuals cannot escape from poverty. In short, the Goals cannot be achieved without effective health systems that are accessible to all.

Report on Mission to Romania. This report (E/CN.4/2005/51/Add.4) was submitted to the Commission on Human Rights on 21 February 2005

E. Environmental health

69. Environmental health problems arise from, inter alia, limited access to safe drinking water, inadequate sanitation, air pollution and the contamination of water by industrial effluents. These factors directly affect the health of communities across Romania, in particular rural communities, and children. Because of space constraints, this chapter gives attention to just one environmental health issue, access to safe water and adequate sanitation, which is an underlying determinant of the right to health, and reflected in Millennium Development Goal 7.

70. The Government of Romania has made progress in improving access to safe water by connecting homes to the water supply system. In 1992, 85 per cent of the urban population and 16 per cent of the rural population had their houses connected to water supply systems (47 per cent of Romania's population lives in rural areas). By 2002, 92 per cent of inhabitants in urban areas and 34 per cent in rural areas were connected. The Government's target is to connect 99 per cent of the urban population and 85 per cent of the rural population to local water supply networks by 2020.

71. Even in view of progress to date, a significant proportion of Romania's population remains without access to the water supply system. Many households continue to draw water from wells or rely on piped surface water, both of which are especially susceptible to bacterial imbalance and contamination, including from pesticides. Some reports even suggest worsening water quality. Poor sewerage coverage in rural areas creates a further risk of contamination of drinking water - in 2001, the homes of 85 per cent of urban residents but just 11 per cent of rural residents were connected to sewers. Incidence of some water-borne or sanitation-related diseases is high. Rates of viral hepatitis A, which declined in the 1990s, are still double those in other Central and Eastern European countries, while rates of diarrhoea are also high.

72. The Government informed the Special Rapporteur that systems are in place to monitor water quality and that information and advice about which sources of water are safe is available to individuals, families and communities. The Government reported that in spite of these measures, people continue to draw water from unsafe sources.

73. The right to health gives rise to an entitlement to geographically accessible safe drinking water and adequate sanitation. For example, in article 24, paragraph 2 (c), the Convention on the Rights of the Child places an obligation on States parties to combat disease, including through the provision of clean drinking water. **The Special Rapporteur welcomes progress to date, but urges the Government to take all necessary measures to ensure it fulfils these human rights obligations and achieves the targets it has established. He also encourages the Government to continue and to deepen its policies and programmes to monitor water quality and to continue its efforts to raise awareness among communities about where they can obtain safe water, as well as the health consequences of drinking contaminated water.**

F. Roma

74. The Roma population, one of several minority ethnic groups in Romania, is estimated to number around 1,500,000. Homelessness and vulnerability to forced evictions, overcrowded living conditions and a lack of access to safe water and adequate sanitation are problems disproportionately affecting the health of Roma. Other obstacles to their right to health include low levels of education, poor nutrition, poor communication between health professionals and Roma health system users, and lack of access to information on health issues. Besides, many Roma do not have identity cards and documentation, which precludes access to health insurance. A survey in 2000 estimated that only 34 per cent of Roma had cover from the health insurance fund compared to the national average of 75 per cent. The lack of identity cards or other documentation denies some Roma the opportunity to benefit from the health insurance fund. Life expectancy and infant mortality rates are respectively 10 years shorter, and 40 per cent higher among Roma than among the general population.

Report on Mission to Peru. This report (E/CN.4/2005/51/Add.3) was submitted to the Commission on Human Rights on 4 February 2005

15. Peru has the highest incidence of pulmonary tuberculosis in Latin America, with 100 cases per 100,000 population, compared with the regional average of 17 cases, and a high incidence of multi-drug-resistant tuberculosis. The incidence of HIV/AIDS in Peru is increasing, and an estimated 72,000 people are currently living with HIV/AIDS. Malaria is widespread, in particular in the jungle (*selva*) region, and Peru's population is vulnerable to other infectious diseases such as leishmaniasis. Thirty per cent of the urban population and 60 per cent of the rural population still do not have access to safe water or adequate sanitation. Environmental determinants of health, such as unsafe drinking water, inadequate sanitation, as well as air and water pollution, exert a heavy toll on the health of the population. Malnutrition affects the health of up to 25 per cent of children under the age of 5, while obesity is also an increasing problem, especially in urban areas. Between 1980 and 2000, internal conflict led to the death or disappearance of an estimated 69,000 people, caused widespread psychosocial health problems, and contributed to a culture of violence that continues to have an impact on health in Peru today.

The impact of poverty and discrimination

16. Many of the health problems in Peru are inextricably linked to problems of poverty and discrimination, which are among the causes and consequences of ill-health in the country. People living in poverty have poorer access to basic services, such as clean water, sanitation and health care. Ill-health also often impoverishes individuals and families on account of the cost of treatment or because of its impact on revenue-generating activities. Some diseases, including HIV/AIDS, have given rise to multiple forms of discrimination against those affected, which further impedes the enjoyment of the right to health and other human rights. Poverty and discrimination have perpetuated great disparities in the enjoyment of the right to health between rural and urban areas, between regions and among different population groups.

(...)

20. Poverty, discrimination, and a lack of adequate targeting of the health needs of particular population groups have all contributed to these health-related vulnerabilities. **In these circumstances, the main right to health challenge is to identify policies and implement strategies that (i) are based on equity, equality and non-discrimination; and (ii) improve access to health care, and the underlying determinants of health, of those living in poverty. This overarching challenge provides the main theme that recurs throughout this report.**

(...)

B. Environment and health

52. Environmental health problems arise from a lack of access to safe water, inadequate sanitation and contamination by extractive industries, and affect the health and livelihoods of communities across Peru. These problems disproportionately affect vulnerable groups, including people living in poverty, indigenous peoples and children. The Special Rapporteur visited several areas affected by such problems, including Belen municipality (Iquitos, Department of Loreto), Callao and San Mateo de Huanchor (Department of Lima), where he met with local authorities, non-government organizations and affected communities. He makes the following observations:

(a) *Belen*. The population of Belen has dramatically increased in the last two decades on account of rural to urban migration. The residents of Belen are among the poorest in Iquitos and live in overcrowded conditions in housing elevated above the flood plain of the river Nanay. Over half of Belen's residents lack access to safe water and adequate sanitation and the river is contaminated with mercury due to activities of companies dredging for gold upstream. The incidence of water-borne diseases and acute diarrhoea is high and particularly affects infants and children. The infant mortality rate in Belen is high - 4.9 per cent. The Special Rapporteur was impressed with the commitment of the municipal and regional authorities, and local civil society, to redress these, and other, poverty-related problems. Local authorities have developed plans to build sanitation facilities in the area, but there is as yet no budgetary allocation to support implementation;

(b) *Callao*. Callao has played an historic role in Peru's economic development: most of Peru's exports, including mineral products, leave the country through its port. Transportation of lead ore to and from, and storage in, large depots in Callao has resulted in lead poisoning. In a recent survey, over 50 per cent of local children were found to have over twice the permissible limit of blood lead concentration defined by WHO. Most recently, these activities have been undertaken by private sector companies, following privatization of State mining enterprises during the 1990s. A representative from two of these companies informed the Special Rapporteur that storage and transportation of lead has been improved, although he noted that pilfering of ore during transportation still occurs and contributes to contamination. Others informed the Special Rapporteur that the depots, including the movement of materials in and out, were still causing local contamination. At any rate, studies suggest that the levels of lead in children's blood remain dangerously high;

(c) *San Mateo de Huanchor*. The Special Rapporteur was informed about the impact of toxic mine tailings, including arsenic, lead, mercury and cadmium, on the health of the community of San Mateo, including indigenous peoples and children. While mining activities are currently halted, contaminating waste in the tailing pit has not been removed, despite an order to this effect made by the Government to the concerned company (Wiese Sudameris). Since domestic remedies have not been forthcoming, this case was submitted as part of a broader complaint by CONOMACI to the Inter-American Commission on Human Rights, which has requested precautionary measures and decided,

in November 2004, that this case is admissible and invited the parties to find a friendly settlement.

53. The Special Rapporteur's investigations into problems in Callao and San Mateo afforded him the opportunity to learn about the apparent disregard of human rights, including the right to health, by the private mining sector and some government departments. The Special Rapporteur received information indicating that these are not isolated cases, but illustrative of a wider problem. He notes that the original complaint submitted by CONOMACI to the Inter-American Commission includes not only the cases of Callao and San Mateo, but another 13 cases involving, among other things, poisoning of children, environmental contamination and illegal expulsions from land, affecting local communities located near foreign and domestic mining projects. Meanwhile, while the lack of access to clean water and sanitation has a particularly acute impact on the health of the residents in Belen due to poverty, overcrowding and flooding, many communities across the country face similar problems.

54. The right to health, as well as the rights to water and adequate housing, give rise to obligations on States to ensure an adequate supply of safe and potable water and adequate sanitation. The right to health also gives rise to an obligation to prevent and reduce the population's exposure to harmful substances that impact upon health. Environmental contamination, as well as inadequate water and sanitation, can have a particularly severe impact on children, and hinder their enjoyment of the right to health. In particular, the Special Rapporteur notes that the Government of Peru not only has an obligation to respect the right to health, but to protect this right against harm by third parties. As a State party to the Convention on the Rights of the Child, Peru has an obligation to "combat disease ... through, inter alia, the application of readily available technology and through the provision ... of clean drinking water, taking into consideration the dangers and risks of environmental pollution (art. 24 (2) (c))". As a State party to ILO Convention No. 169, the State also has a particular obligation to protect the right to health and other related human rights of indigenous peoples.

55. Promoting health must involve effective community action in setting priorities, making decisions, and planning, implementing and evaluating strategies to achieve better health. All individuals and groups have the right to participate in decision-making processes that may affect their health or development. **The Special Rapporteur recommends that the Government give urgent attention to fulfilling this right to participation at all stages of development or mining projects, including planning, development, implementation and monitoring.**

56. **The Special Rapporteur recommends that the Government ensure that independent rights-based environmental and social impact assessments are conducted prior to the setting up of all mining or other industrial projects that may have harmful impacts on the right to health.**

57. Any alleged victim of a violation of the right to health who has suffered harm should have access to effective judicial or other appropriate remedies at both national and international levels, as well as adequate reparation in suitable cases.

58. The Special Rapporteur urges the Government to appoint a high-level, wide-ranging, independent public inquiry to investigate the situation in Callao and make recommendations as a matter of urgency. The inquiry should take into account all relevant national and international law, including human rights, and consider all reasonable solutions, including the closure and removal of the facilities to a different location.

59. The Special Rapporteur also urges the Government to comply with the precautionary measures requested by the Inter-American Commission in the case of San Mateo.

60. Concerning water and sanitation, the Special Rapporteur reiterates and endorses the relevant recommendations of the Special Rapporteur on the right to adequate housing (E/CN.4/2004/48/Add.1, paras. 23-25). He also urges regional, national and international institutions to ensure that technical and financial resources are made available to support the plan to bring sanitation and safe water to Belen, and all comparable communities.

(...)

E. Ethnicity and culture

79. The Special Rapporteur is deeply concerned about disparities in access to health services and goods for marginalized groups in Peru, including indigenous peoples and ethnic minorities. These disparities are rooted in geographic, cultural, economic and linguistic barriers. Indigenous peoples and ethnic minorities are also particularly vulnerable to other particular health problems: in some places, mineral extraction has led to environmental degradation and contamination of their water sources and food supplies; they were disproportionately affected by Peru's internal conflict; and thousands of indigenous women, primarily those living in poverty and in rural areas, are believed to have been sterilized without their consent during the family planning programme carried out during the 1990s. Despite these serious issues, some of which were discussed during the Special Rapporteur's visits to Ayacucho and Iquitos, the obstacles to the enjoyment of the right to health of indigenous peoples were not extensively documented in the significant amount of material made available to the Special Rapporteur, and were seldom raised by those with whom he met in Lima.

Report on Mission to Mozambique. This report (E/CN.4/2005/51/Add.2) was submitted to the Commission on Human Rights on 4 January 2005

A. Poverty

18. Health problems in Mozambique must also be understood in the context of widespread poverty. In the UNDP Human Development Index (2003), Mozambique was ranked 170 out of 173 countries. Mozambique's gross domestic product is US\$ 230 per capita, well below even the average for least developed countries (LDCs). Approximately 70 per cent of the population live below the poverty line.

B. Prevention, treatment and control of diseases

19. In Mozambique, HIV/AIDS, malaria, diarrhoea and tuberculosis are major causes of morbidity and mortality. An estimated 13-16 per cent of Mozambique's population is living with HIV/AIDS. Malaria accounts for 30-40 per cent of under-five deaths, and is a particular problem in some rural areas. Water- and sanitation-related diseases, such as diarrhoea, cholera, dysentery, malaria, scabies and schistosomiasis, are widespread and account for a large part of ill-health reported by communities. Mozambique is also vulnerable to outbreaks of meningococcal meningitis and bubonic plague, in particular in urban areas. Leprosy continues to affect people in certain parts of the country, although in recent years significant progress has been made towards its eradication.

20. The prevention, treatment and control of epidemic, endemic, occupational and other diseases is a central obligation of the right to health. States must take steps to ensure access to goods, facilities and services for the prevention and treatment of diseases, including ensuring access to medication related to HIV/AIDS, malaria and tuberculosis; establish prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases; and ensure access to adequate sanitation and potable drinking water.

(...)

E. Water and sanitation

62. The right to health extends beyond the right to health-care services and includes the right to underlying determinants of the right to health such as water and sanitation. In Mozambique, water and sanitation are characterized by low levels of coverage, poor services delivery and weak sustainability; 75 per cent of the rural population and 60 per cent of the urban population lack access to adequate sanitation facilities, and 71 per cent of rural and 64 per cent of the urban population do not have access to safe water supplies. Water- and sanitation-related diseases such as malaria, cholera, diarrhoea, scabies and schistosomiasis are common.

63. The Government has made some progress towards improving access to safe drinking water and adequate sanitation. A National Water Policy was developed in 1995, followed

by a Rural Water Transition Plan in 1997. Efforts have been made to establish an institutional framework for implementation of these policies. However, major gaps will need to be addressed in order to meet the Millennium Development Goals, including the need to ensure adequate programmes to promote sanitation and hygiene behaviour; the involvement of users in the implementation of projects; and the empowerment of women as “agents of change” in hygiene practices. **Particular attention must be paid to addressing the needs of rural populations. The Special Rapporteur also urges the Government of Mozambique and its funding partners to establish a Common Fund for water and sanitation services, along the lines of the Common Fund for the health sector.**

F. Availability of resources

78. Despite the significant focus on health in the Millennium Development Goals, the health sector does not appear to be a priority for the World Bank in its assistance to Mozambique. The World Bank’s support of the health sector is very modest, approximately 13 per cent of total World Bank support, compared to 14 per cent in water and sanitation, 16 per cent in education, and 38 per cent in transport. The first poverty reduction support credit (PRSC) disbursed by the World Bank does not include funds for the health sector. **The Special Rapporteur is concerned at this limited support and suggests that the World Bank include a greater focus on assistance to the health sector. He encourages the World Bank to ensure that its second PRSC gives due attention to the health sector, in addition to other sectors vital to poverty reduction, human rights and health, such as water and sanitation.**

Report on Mission to Uganda. This report (E/CN.4/2006/48/Add.2) was submitted to the Commission on Human Rights on 19 January 2006

8. Although neglected diseases are by no means homogeneous, it has been noted that many share the following common characteristics:

(a) They typically affect neglected populations - the poorest in the community, usually the most marginalized and those least able to demand services. These often include women, children and ethnic minorities, displaced people, as well as those living in remote areas with restricted access to services. Neglected diseases are a symptom of poverty and disadvantage;

(b) The introduction of basic public health measures, such as access to education, clean water and sanitation, would significantly reduce the burden of a number of diseases. Improved housing and nutrition would also help in some cases;

(...)

13. By 2004, an estimated 1.6 million people were displaced and confined to about 200 temporary settlements, with populations ranging from 500 to 60,000 per settlement. These people live without independent means of subsistence, and many live in

inadequately protected and serviced camps where they continue to suffer from violent attacks by LRA. Access to clean drinking water, adequate sanitation and basic health services in many of the camps is extremely limited, a situation which has fuelled high levels of morbidity and mortality. Poverty levels in Northern Uganda average between 38 and 67 per cent, compared to other regions with an average of 20 per cent poverty. A recent survey by WHO found that crude mortality rates in Gulu, Kitgum and Pader were above the emergency threshold of 1 death per 10,000 per day, and well above the nationwide rate of 0.46 for Uganda.

(...)

17. The Constitution of the Republic of Uganda is grounded in basic human rights principles, including non-discrimination and equality for all citizens, with specific provisions to ensure the human rights of women, people with disabilities and children. Preambular paragraph XX provides that the State shall take all practical measures to ensure the provision of basic medical services to the population, while other sections commit the State to promoting access to the underlying determinants of health, such as water, encouraging the production and storage of food, and promoting nutrition through education and other means to support a healthy population. Preambular paragraph XIV (ii) states that all Ugandans shall enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.

(...)

D. Health challenges in Uganda

23. However, significant health challenges persist. Access to health-care facilities is limited by poor infrastructure, especially in the rural areas where only 49 per cent of households have access to health care. Communicable diseases such as malaria, parasitic infection, HIV and TB are widespread and contribute to high levels of morbidity and mortality. Poor sanitation and water fuel high rates of cholera, diarrhoea, schistosomiasis and malaria among certain populations. According to reports, recently the Government has shifted away from its comprehensive HIV-prevention policy towards an emphasis on abstinence. In addition, the country has experienced a severe shortage of condoms since late 2004 as a result of problems related to procurement and timely distribution. These factors reportedly have contributed to a recent rise in HIV-infection rates, which have climbed to 7 per cent for men and 9 per cent for women nationally. At the same time, in August 2005 the Global Fund to Fight AIDS, Tuberculosis and Malaria announced the suspension of all its grants to Uganda due to “evidence of serious mismanagement” of the funds.

(...)

25. Maternal mortality rates in Uganda have stagnated at 505 deaths per 100,000 births. Women also suffer disproportionately from diseases, due to a variety of sociocultural,

economic and biological factors, and bear the burden of caring for family members afflicted with illnesses such as HIV/AIDS, malaria and lymphatic filariasis. High rates of domestic violence in Uganda further contribute to the overall burden of ill health for women. The Government has established a Task Force on Infant and Maternal Mortality with responsibility for producing a national strategy to address the problem. However, the MDG targets related to the reduction of child and maternal mortality will not be achieved if serious measures are not adopted through a number of sectors, such as health, education and water.

(...)

E. Neglected diseases

27. In all cases, neglected diseases affect the most marginalized populations in Uganda. Those who have been displaced as a result of the conflict are particularly vulnerable, as they subsist in camps with poor sanitary conditions, overcrowding, inadequate shelter, lack of access to safe and potable water, and limited access to health services. Although medical services are provided in some camps by the district's health system, less than half of the population in Gulu, Kitgum and Pader districts has access to health-care services within 5 km walking distance.

28. Neglected communities in urban areas also are vulnerable to neglected diseases. The Special Rapporteur visited the urban slum areas of Kampala, including Kisenyi, where the lack of an effective system for draining surface water during the rainy season adds to regular flooding in the area and exacerbates unsanitary conditions. Moreover, the slums lack effective sanitation systems and very few public latrines are available to the population.

29. These conditions facilitate the transmission of diseases which persist in conditions of poverty, where they cluster and frequently overlap. Unsafe water and poor sanitation sustain transmission cycles and favour the proliferation of vectors. A lack of access to health-care services, low levels of literacy, inadequate nutrition and poor personal hygiene all help to increase vulnerability to infection and work against prevention and treatment efforts.

Report on mission to Lebanon and Israel conflict of August 2006. This report (A/HRC/2/7) was jointly submitted by four mandate holders to the Human Rights Council on 2 October 2006

12. While the fighting continued after the adoption of Council resolution 1701 (2006) and even intensified up to the last moment, the cessation of hostilities took effect on 14 August 2006 at 8 a.m. Immediately afterwards, in both countries persons displaced by the conflict began returning in large numbers to their areas of residence. The homes of many returnees to southern Lebanon had been destroyed, and they faced shortages of water and electricity as well as very limited access to health and other public services damaged during the conflict. Unexploded ordnance, especially cluster bomblets, also presented

great dangers to the civilian population, particularly in southern Lebanon. Returning Israelis found homes and other amenities destroyed and damaged.

(...)

62. The destruction of thousands of homes forced many displaced families to live in situations marked by high density, lack of access to water, sanitation, electricity, health care and generally insecure housing and living conditions. Others were forced to live in the open in places such as the Samaya Garden. This impacted on the well-being of individuals and families and contributed to mental health problems, especially among women and children.

63. One of the requirements of the right to the highest attainable standard of health is that health care be accessible to all, including children, the elderly, women, people with disabilities, and other especially vulnerable individuals and groups. During the conflict, the remaining inhabitants of a number of villages in South Lebanon became extremely isolated, seriously jeopardizing their access to elementary health care. While many inhabitants fled, most of those remaining were elderly or people with disabilities. Their acute vulnerability was compounded by the security situation, which made it dangerous for anyone to travel. The destruction of roads and bridges made it very difficult for the villages to be reached by emergency medical and other services. If pre-packaged emergency medical kits reached the isolated communities, the contents of the kits did not always cater for the distinctive chronic health problems of the elderly (e.g. hypertension and diabetes), although agencies tried to supplement the kits as necessary. Inhabitants who were able to leave their villages to seek medical care often found the local health clinics destroyed, damaged or closed (see para. 47 above). During hostilities, access to mental health care became a major issue: in the last week of the conflict, Médecins sans Frontières reported that 20-30 per cent of all its consultations related to mental health problems. These isolated communities of especially vulnerable people also suffered from a lack of other elements of the right to the highest attainable standard of health, including access to water (see para. 89 below). Although the problem of access to basic health care was especially grave in relation to these isolated rural communities, the problem extended beyond these villages.

64. The same communities also suffered from severe problems relating to denials of the right to adequate housing, such as access to potable water, sanitation and electricity.

(...)

84. While each category of person faces specific problems, the main obstacles to the resumption of a life in safety and dignity are to a large extent shared by persons still displaced, returnees, and those who did not leave their homes in South Lebanon during the conflict. In Lebanon, the major obstacles to resumption of normal life in the affected areas are the violations of the right to adequate housing and health, including the destruction of housing, lack of access to water, electricity and sanitation, and the dangers of unexploded ordnance.

(...)

89. Damage to medical facilities combined with shortages of fuel, power, water and supplies have had a major impact on service delivery throughout the districts affected by the conflict. There is a serious gap, for example, in maternal and child care services. Just one in four primary health care facilities are able to provide pre-natal care, and just one in 10 can support proper delivery and emergency obstetric care. One third are able to store vaccines and just 13 per cent are able to provide some mental health services. Normally, all of these facilities should be able to provide all of these services. The situation remains particularly acute in those communities in the south that were badly damaged during the conflict (see para. 63 above). The conflict is likely to have deepened pre-existing inequalities in the delivery of health care services in Lebanon.

90. The right to the highest attainable standard of health not only encompasses health care, but also access to the underlying determinants of health, such as adequate water and sanitation. Access to water, sanitation and electricity are also essential elements of the right to adequate housing. In Lebanon, inadequate access to water, sanitation and electricity remain among the most serious problems arising from the recent conflict. Local distribution networks (i.e. pipes) have been badly damaged and sewage and garbage collection systems have been interrupted, leading to an increased risk of waterborne diseases. Isolated enclaves in the south continue to have limited access to safe water, mainly because of the destruction of many private and community-owned water tanks, the damage to the distribution system and the disrupted electricity supply. The Stockholm Conference for Lebanon's Early Recovery estimated the damage to the water sector at US\$ 81 million, more than a quarter of which will be required for South Lebanon.

(...)

103. The mission makes the following recommendations to the Government of Israel:

(...)

(d) While Israel indicated that it had a policy not intentionally targeting water and power installations, such objects were nevertheless damaged by Israeli attacks. Given the extremely damaging effects on the civilian population of such attacks, the mission urges the Government, as a matter of priority, to formalize its policy in this respect;

104. The mission makes the following recommendations to the Government of Lebanon:

(...)

(d) The conflict highlighted serious flaws in Lebanon's health system, such as the absence of an adequate health information system, as well as striking inequalities in access to a uniform package of health care. Because these deficiencies impede the population's ability to recover from the conflict, the Government is urged to work vigorously towards establishing an effective, integrated, responsive health system accessible to all, especially children, women, the elderly, people with disabilities and those living in poverty. The immediate challenge is to meet the health needs of those who are displaced, as well as those who have lost their homes and livelihoods. In the medium term, the priority is to re-establish and improve the medical, water, sanitation and electrical facilities in the areas most affected by the conflict;

(...)

(f) The Government should develop, in cooperation with the international community, a comprehensive strategy to assist internally displaced persons and returnees taking into account the most vulnerable groups such as women heads of household and children or elderly people without family support. Such a strategy should use a rights-based approach, in line with the Guiding Principles on Internal Displacement, and urgently address the following protection challenges: (i) access to basic services (in particular shelter, water, sanitation, education and health) for returnees and for the poor and vulnerable among those who continue in displacement; (ii) access to livelihoods, in particular in farming areas affected by UXO; (iii) protection in cases of domestic violence, which are likely to increase in situations of stress and cramped housing and living conditions; and (iv) access to courts and other conflict resolution mechanisms in the context of property disputes that might occur in South Beirut and parts of southern Lebanon.

30 May 2007