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Strategic priorities of work

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

Summary

The present report contains a brief account of the activities undertaken by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, since she assumed the functions of the role on 1 August 2020, and identifies the priority themes for her work in the coming years.

The main approach of the Special Rapporteur will be to examine the understanding of coloniality and racism, their impact on the right to health and how to move forward to substantive equality. In the report, she argues that substantive equality as a goal allows for the addressing of structural and indirect discrimination and for the identification and elimination of the power dynamics that have perpetuated the systems and patterns of privilege and disadvantage that outlived formal colonialism. To achieve substantive equality in the realization of the right to health, laws and policies should address the intersectional nature of discrimination, namely the lived experiences of those who experience discrimination on multiple grounds. In particular, the Special Rapporteur plans to look into the interrelated and entrenched obstacles operating at different levels that stand between individuals and their enjoyment of sexual and reproductive health rights.

The present report includes seven priority themes that will be elaborated throughout the tenure of the mandate holder and also contains two additional issues that will be examined further.

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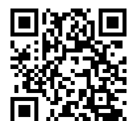

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I. Introduction

1. The present report is the first submitted to the Human Rights Council by the newly appointed Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, and was prepared pursuant to Human Rights Council resolution 42/16.

2. In the report, the Special Rapporteur provides a brief account of her activities since her appointment, including communications and cooperation with the United Nations system and other key stakeholders.

3. The Special Rapporteur reflects on how she sees the way forward for the work of the mandate, based on the current context, challenges and opportunities for the full realization of the right to health. She lays out the main themes as priorities for the coming years. In the final chapter, the mandate holder provides her conclusions.

II. Activities during the reporting period

4. Between 1 March 2020 and 25 February 2021, the Office of the Special Rapporteur sent 134 communications to 61 States and 10 private companies, and 6 communications to other actors, including the Secretary-General and the European Commission. Of the 140 communications sent, a total of 81 (58 per cent) addressed right-to-health violations directly linked to the coronavirus disease (COVID-19) pandemic. At the time of writing, a total of 73 responses had been received, indicating a response rate of 52 per cent.

5. Between August 2020 and February 2021, the Special Rapporteur participated in sessions, meetings and events linked to the discharge of her mandate, all of them held remotely owing to the COVID-19 pandemic. Among those was the induction course for new mandate holders, held 14 to 18 December 2020, and the seventy-fifth session of the General Assembly where, on 29 October 2020, she presented the last report of her predecessor.

6. The Special Rapporteur also engaged with other parts of the United Nations system and regional mechanisms, including the Commission on Narcotic Drugs; the World Health Organization (WHO); the East and Southern Africa Regional Office of the United Nations Population Fund; Every Woman, Every Child's Independent Accountability Panel; and the World Bank.

7. In addition, the Special Rapporteur held consultations with a wide range of stakeholders from civil society, academia and medical professional organizations, either bilaterally or collectively, to report on and define her priorities for her tenure.

III. The way forward: context, challenges and opportunities

8. As stated by American writer, feminist and human rights defender Audre Lorde, "there is no such thing as a single-issue struggle because we do not live single-issue lives".[1] What she articulated, years before the language existed, is best viewed through the lens of intersectionality, which originated as a theoretical lens, conceptualized by Kimberle Crenshaw in 1989.[2] It is a lens through which to view and understand the experience of Black women in the United States of America, who were inadequately catered to by social justice discourses that separated race and gender. It has since been used as a tool to recognize the ways in which multiple oppressions intersect to produce complex lived experiences.[3]

[1] Statement by Audre Lorde, "Learning from the 60s", during the celebration of the Malcolm X weekend at Harvard University, February 1982. Available at www.blackpast.org/african-american-history/1982-audre-lorde-learning-60s/.

[2] Kimberle Crenshaw, "Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics", *University of Chicago Legal Forum*, vol. 1989 (1).

[3] The Special Rapporteur on the rights of persons with disabilities has applied the concept of intersectionality in previous reports. See, for example, A/HRC/34/58, A/72/133 and A/74/186.

9. The Special Rapporteur will address the most important issues related to the discharge of her mandate with that in mind. Enhancing this viewpoint is an understanding of coloniality and racism and its impact on the right to health. Coloniality, a concept coined by Walter Mignolo around 1995,[4] refers to the living legacies of European colonialism in social orders and knowledge systems, which created racial hierarchies that enable the social discrimination that has outlived formal colonialism. It is with this in mind that advocating for the intentional institutionalization of anti-racism in the public health architecture systems – and therefore the realization of the right to health for all – must be a primary focus not only in the work of the Special Rapporteur, but of all proponents of the right to health.

10. Eliminating discrimination in practice requires paying sufficient attention to groups of individuals that suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. This is a necessary measure to ensure a nuanced understanding and the use of collective power to win freedom for all oppressed people.

11. The Special Rapporteur will advocate for the application of the right to health framework to deepen understanding of the negative impact of coloniality, racism and the oppressive structures embedded in the global health architecture, which disproportionately affects Black people, indigenous communities and other groups who are racially discriminated against in the global South.

12. She will also reflect further on what the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance discussed in a report of 2018. In that report, the Special Rapporteur discussed the importance of an intersectional approach to racial discrimination in the context of citizenship, nationality and immigration laws that accounted for the compounding and differential effects of sex and gender, among other factors, and noted that States continued to enforce patriarchal laws that used gender-based discrimination to achieve racial, ethnic and religious exclusion.[5] The Special Rapporteur on the right to health agrees that States should comply with international human rights standards when implementing laws and policies regarding citizenship, nationality and immigration, and that they should fulfil their obligations to achieve substantive racial equality.

13. The Special Rapporteur will emphasize the need to place substantive equality in the centre of the operationalization of the right to health. This requires an unequivocal commitment to the realization of universal human rights principles as enshrined in the Universal Declaration of Human Rights and other international human rights instruments, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination and the Durban Declaration and Programme of Action. The Durban Declaration and Programme of Action is a comprehensive, action-oriented document that proposes concrete measures to combat racism, racial discrimination, xenophobia and related intolerance.

14. Substantive equality seeks to address structural and indirect discrimination and takes into account power relations. It acknowledges that the "dilemma of difference" entails both ignoring and acknowledging differences among human beings in order to achieve equality.

15. The mandate holder will look into how gender reaches into disability; disability wraps around class; class strains against abuse; abuse snarls into sexual orientation; and sexual orientation folds on top of race, with everything finally piling into a single human body.[6] In particular, she will look into the obstacles that stand between individuals and their enjoyment of sexual and reproductive health rights. These obstacles are interrelated and entrenched, operating at different levels: in clinical care, at the level of health systems, and in the underlying and social determinants of health.

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[4] Walter Mignolo, *The Darker Side of the Renaissance: Literacy, Territoriality, and Colonization* (Ann Arbor, University of Michigan Press, 1995).

[5] A/HRC/38/52, para. 12.

[6] Eli Clare, *Exile and Pride: Disability, Queerness and Liberation*, Cambridge: South End Press, 1999, p. 123.

16. The Special Rapporteur plans to apply a life-cycle approach to her work, paying special attention to groups in vulnerable situations, or that have historically been subjected to discrimination. In addition, she will continue to pay attention to the issue of criminalization of: same-sex relations; being trans-diverse or transgender; abortion; sex work; and health status, such as being HIV-positive or being diagnosed with COVID-19 infection. She aims to make proposals for States to mainstream a gender perspective in their health-related policies, planning, programmes and research, with a special focus on sexual and reproductive health rights as an integral part of the right to health.

17. The right to health, as defined by the Committee on Economic, Social and Cultural Rights, 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, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.[7] Furthermore, the right to health is closely related to and dependent upon the realization of other human rights, including the rights to life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.[8]

18. In the current context of the COVID-19 pandemic, in the last decade of working to achieve the Sustainable Development Goals, the mandate holder will strive to ensure continuation of the work of her predecessors regarding: identification of good practices; health-care workers, as they are essential to ensure availability, acceptability, accessibility and quality of health-care services; and the effective operationalization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. She plans to elaborate on the health, mental well-being, allowances and remunerations of health-care workers, and fairness in the workplace, so they can deliver quality health-care services.

19. The COVID-19 crisis has reminded the global community that the realization of the right to health is interdependent, indivisible and interrelated with other human rights, and the outcome of a successful process of achieving the Sustainable Development Goals requires global solidarity and equity in accessing essential medicines, including COVID-19 vaccines, and sharing scientific knowledge widely. Mechanisms of accountability are crucial for ensuring that States' obligations arising from the right to health are respected, protected and fulfilled.

A. Policy approach to the right to health: a focus on non-discrimination in sexual and reproductive health rights

20. WHO[9] indicates that sexual health is fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships. It also requires the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships and pleasure.

21. The challenges that stand between individuals and their enjoyment of sexual and reproductive health rights operate at different levels: in clinical care, at the level of health systems, and in the underlying and social determinants of health. The key principles that

[7] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 11.

[8] Ibid., para. 3.

[9] See, for example, WHO, "Sexual health and its linkages to reproductive health: an operational approach" (Geneva, 2017).

shape human rights, especially non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of individuals, especially in relation to sexual and reproductive health rights, are integral to the realization of the right to health.

22. It is therefore important to have a policy approach that acknowledges that the concept of sexuality is not linked only to the ability to reproduce. Achieving sexual health and well-being depends on: access to comprehensive, good-quality information about sex and sexuality; knowledge about the risks the concerned individuals may face and their vulnerability to adverse consequences of unprotected sexual activity; ability to access sexual health care; and living in an environment that affirms and promotes sexual health. These elements will ensure that we truly "leave no one behind".

23. The Special Rapporteur expresses her support for the Declaration of Principles on Equality,[10] which was adopted by a number of experts in 2008 and which emphasizes that equality is integral to the enjoyment of all human rights, recognizing not only that each kind of inequality is unique but also that different inequalities exist under overarching aspects that connect them. Referring to the Declaration, it has been noted that the unified framework highlights the intersections between:

(a) Types of discrimination based on different prohibited grounds, such as race, gender, religion, nationality, disability, sexual orientation and gender identity;

(b) Types of discrimination in different areas of civil, political, social, cultural and economic life, including employment, education, and provision of goods and services;

(c) Types of discrimination in respect to the enjoyment and exercise of different human rights;

(d) Status-based discrimination and socioeconomic inequalities.[11]

24. In the light of advancing health equity, intersectionality has transformative power in national legal and policy frameworks to promote substantive equality that drives progressive jurisprudence in countries. One such approach is looking at national normative frameworks, including at the role of legislation and litigation through the courts, which inter alia underlines the importance of the justiciability of the right to health. An important consideration about intersectionality as it pertains to discrimination embedded in national policy, legislative frameworks, and hostile laws and criminalization, is that it is only useful if interpreted in the light of a certain purpose.

25. It has also been noted that intersectionality as a concept does not spontaneously encourage custodians of the law, such as judges, to decide in favour of people in severe marginalized situations who experience multiple intersections of oppression, and against people in positions of power or privilege. This provides motivation for national laws to be examined not only for their protection of human rights, but also for their potential to pivot towards abuses of human rights.

B. Substantive equality approach to the right to health

26. The starting point of millions of people around the globe is unequal. This inequality affects an individual's access to the determinants of health, such as education, access to water, clean environment and housing, among others, which in turn affect the individual's health outcomes. Therefore, adverse health outcomes are not only about individual predisposition or genetics, but also about oppressive systems that established racial

[10] The Declaration of Principles of Equality was adopted in 2008 during the conference "Principles on equality and the development of legal standards on equality", organized by the Equal Rights Trust in London. The conference was attended by 128 experts with different backgrounds, including academics, legal practitioners and human rights activists, from more than 40 countries. Text of the Declaration is available at www.equalrightstrust.org.

[11] Dimitrina Petrova, "Editorial" in *Equal Rights Review – Special Focus: Intersectionality*, vol. 16 (London, 2016), pp. 7–8.

hierarchies, which enable enduring social discrimination beyond formal colonial structures and continue to perpetuate health inequalities.

27. The Special Rapporteur will build on the work done by previous mandate holders, highlighting equality as an essential element of the right to health. Throughout her work, she will strive to differentiate formal equality from substantive equality so as to achieve the latter. Formal equality seeks to combat direct discrimination by treating persons in a similar situation similarly. It may help to combat negative stereotyping and prejudices, but it cannot offer solutions for the "dilemma of difference", as it does not consider and embrace differences among human beings.

28. Substantive equality, by contrast, also seeks to address structural and indirect discrimination and takes into account power relations. It acknowledges that the "dilemma of difference" entails both ignoring and acknowledging differences among human beings to achieve equality.[12] Substantive equality is a principle that underscores the need to ensure true equality in outcomes. To achieve substantive equality, systems and processes must be put in place to ensure equal access to opportunities and services, and to also ensure that people can access them in a manner that meets any unique needs and circumstances.

29. By acknowledging that the "dilemma of difference" entails both ignoring and acknowledging differences among human beings, substantive equality seeks to address structural and indirect discrimination and takes into account power relations in achieving equality.

30. The Special Rapporteur underscores that, despite the fact that equality and anti-discrimination laws in recent years have been enacted and implemented nationally, regionally and internationally, equality remains out of reach for many. Thus, to remedy this persistent inequality, substantive equality must be adopted as a goal that all nations should work towards. This approach allows us to address inequality as a problem of structural power, which creates and perpetuates systems of privilege and disadvantage in society.

31. These systems of privilege and disadvantage have a pervasive effect on both private and public life. They affect the determinants of health and the distribution of basic goods, such as access to health-care facilities, services and goods, and to housing. In addition, they create negative myths and stereotypes, which operate to disadvantage certain groups.

32. To achieve substantive equality in the realization of the right to health, the intersectional nature of discrimination should be addressed, so as to move away from laws and policies that still use "single-axis" models of discrimination and do not address the lived experiences of those who experience discrimination on multiple grounds.

33. Developing an understanding of intersectionality, particularly through the recognition of intersectional discrimination, and through national legal and policy frameworks to seek substantive equality, will make it possible to better identify and eliminate the power dynamics perpetuating the systems and patterns of privilege and disadvantage.

34. Intersectionality, which is a means through which substantive equality is achieved, recognizes that identity cannot be dissected into mutually exclusive categories of experience and analysis. It asserts that identity is a complex amalgamation of different categories and social locations that simultaneously exist to determine an individual's health outcome.

35. In paragraph 10 of its general comment No. 6 (2018) on equality and non-discrimination, the Committee on the Rights of Persons with Disabilities acknowledged substantive equality, stating that equalization of opportunities marked a significant development from a formal model of equality to a substantive model of equality. Formal equality seeks to combat direct discrimination by treating persons in a similar situation similarly. It may help to combat negative stereotyping and prejudices, but it cannot offer solutions for the "dilemma of difference", as it does not consider and embrace differences among human beings.

[12] See Ben Smith, "Intersectional discrimination and substantive equality: a comparative and theoretical perspective", in *Equal Rights Review – Special Focus: Intersectionality*, vol. 16, 2016.

C. Right to health and accountability

36. As highlighted by the previous mandate holder,[13] accountability is essential if the right to health is to be more than a mere aspiration. Accountability's constituent components of monitoring, review and redress help to identify where progress has been made and where progress is lacking. In addition, accountability constitutes a way for duty bearers to explain their actions and make adjustments. It also provides a means for rights holders to engage in the promotion and protection of their rights with those responsible for the realization of rights, and it allows rights holders to seek redress for violations where they have occurred.

37. Building on what has just been discussed, the Special Rapporteur asserts the importance of creating an enabling environment for the protection and promotion of the right to health and other interconnected rights through transparency, trust, remedies, reparations and the use of intersectional frameworks as a means of achieving substantive equality and ensuring that we truly leave no one behind.

38. For example, during the current pandemic, some countries[14] took actions towards the public disclosure of the identity and personal information of individuals affected by COVID-19, without legal frameworks to protect their confidentiality and privacy through clear definitions of personal and medical data. These data are subject to protection and require the development of legal frameworks that forbid their use and prohibit the publication of an individual's COVID-19-related information.

39. The global pandemic has put health data protection safeguards to the test. While public health provides a legal basis for the processing of personal and health-related data for the purposes of fighting and helping to contain a pandemic, the processing of health-related data is legitimate only when it is done in the public interest and, most importantly, when it is done with adequate legal safeguards. A component of the right to health is the right to seek, receive and impart information concerning health issues, but this does not impair the right to have personal health data treated with confidentiality or the right to privacy.

IV. Themes as priorities

A. Global health in the era of the COVID-19 pandemic

40. The analysis of the global COVID-19 pandemic should be based on the extent to which the application of the right-to-health principles are applied in the response to the pandemic. The spread and impact of COVID-19 have shown more than ever how rights are interdependent. The pandemic's disproportionate impact on Black people, indigenous peoples and other racially persecuted groups, such as the Rohingya and Roma,[15] specifically those located in the global South, is rooted in historical and current systems of oppression. It is important to acknowledge that within the global South, there are disparities and inequities to access the determinants of health, a situation that requires stratified responses to the compounded levels of crisis that have an impact on those who are disproportionately affected.

41. COVID-19 is exposing existing structural fault lines, showing us that, even at our best as a global community, health systems were inadequately prepared, insufficiently resourced, and lacked the necessary agility to shift focus onto the global health emergency without putting at risk other rights and essential services. Among others, quality health care and related services are only possible to the extent to which health-care workers receive adequate

[13] A/HRC/32/32, para. 62.

[14] See OHCHR, "Cambodia: UN experts alarmed by 'naming and shaming' of COVID victims", 11 December 2020. See also communication KHM 10/2020, dated 10 December 2020 (https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25768) and MNE 1/2020, dated 8 May 2020 (https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25215).

[15] OHCHR, "Addressing the disproportionate impact of COVID-19 on minority ethnic communities". 24 November 2020. See also A/HRC/46/57.

protection from occupational exposure, experience fairness in the recruitment process and are remunerated fairly.

42. In his report to the General Assembly in 2020, the previous mandate holder concluded that realizing the right to health – whether before, during or after a public health crisis – requires all human rights to be fully embraced.[16] For example, he referred to digital surveillance and immunity documentation, reiterating concern about how the advances in digital technology were reshaping public and private capabilities to carry out, to an unparalleled extent, mass surveillance over entire populations.

43. Throughout the pandemic, the use of these technologies expanded, with drones and street cameras equipped with facial recognition software identifying people in public without masks, or with digital tracing tools that monitor an individual's movements. However, these measures have not taken into account civil society's input in deciding if they are excessive, necessary or even helpful, and they risk having a chilling effect on and breaking down trust within society, owing to their lack of transparency and the obstacles faced in achieving redress if errors occur.

44. The right to health is affected by abuses to dignity and violations of other rights, including the rights to equality, security and equal participation in society. The impact of the COVID-19 pandemic has been determined less by biological factors and more by public health policy, leadership, socioeconomic inequality, systemic racism and structural discrimination. The differences among countries with regard to managing the pandemic have been evident. Countries with less favourable health-care services and more limited access to the determinants of health have experienced a greater burden of COVID-19 cases and deaths from it.

45. Specific examples within countries paint an even more dire picture, owing to, inter alia, an unequal and unfair application of national laws, as is the example of a case in Uganda where, shortly after the emergence of the pandemic, lesbian, gay, bisexual and transgender persons were arrested for allegedly not adhering to social distancing regulations in a raid of a shelter in Kyengera. Various United Nations experts expressed concern that the shelter had been raided on the basis of the perceived sexual orientation and gender identity of the residents. In a press release, they noted that emergency powers to combat crises, such as the COVID-19 pandemic, derived their strength and legitimacy from strict adherence to their object and purpose, and stressed that any emergency response linked to the pandemic must be proportionate, necessary and non-discriminatory. They highlighted that emergency powers that were used for different purposes – and not for a very specific and defined one – could constitute arbitrary use. In this case, concern was expressed about a possible violation of the prohibition of arbitrary detention.[17]

46. It is important to highlight that, even with the overall inequality already evident in the global South, country-specific inequalities in the region deepen that inequality. This must be taken into account when identifying challenges to access the determinants of health where non-discrimination, decoloniality and anti-racism still remain unfulfilled ideals.

47. During the COVID-19 crisis, the human right to safe water and sanitation for all people has been shown to be essential in controlling the spread of the virus, and it has also highlighted its close interlinkages to the right to health. The Committee on Economic, Social and Cultural Rights, in its general comment No. 15 (2002) on the right to water, states that the human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses. It also insists that adequate access to sanitation is fundamental for human dignity and privacy, that the human right to water is indispensable for leading a life in human dignity and that it is inextricably related to the right to the highest attainable standard of health.[18]

[16] A/75/163, para. 104.

[17] OHCHR, "UN rights experts fear Uganda is using COVID-19 emergency powers to target LGBT people", 27 April 2020; and communication UGA 2/2020 (https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25207).

[18] Committee on Economic, Social and Cultural Rights, general comment No. 15 (2002) on the right to water, paras. 1–3 and 29.

48. Access to safe water and sanitation is an essential element of human life and can be one of the factors that ensures it. However, as noted by the Special Rapporteur on the human rights to safe drinking water and sanitation, frequent hand washing is currently one of the most effective preventive measures available to protect against the spread of COVID-19, but one cannot reasonably tell people to wash their hands frequently if they do not have access to safe water.[19]

49. Access to safe water has been of paramount importance during the COVID-19 pandemic where one means of curbing the spread of the virus is regular handwashing with soap and water and sanitizing with alcohol-based sanitizers. In many developing nations, the minimum core obligation of States to provide access to consistent, safe and clean water supply has not been met. In many countries in the global South, for example, the disparities between urban, peri-urban and rural communities continue to bring to light deep inequalities.

B. Sexuality, gender-based violence and femicide

50. In the Declaration on the Elimination of Violence against Women, proclaimed by the General Assembly by its resolution 48/104, the term "violence against women" is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". Pursuant to article 4 (c) of the Declaration, States should exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons.

51. Some studies show that globally, more than one in three women (35.6 per cent) report having experienced physical and/or sexual partner violence, or sexual violence by a non-partner. At the global level, 38 per cent of all murders of women are committed by their intimate partners. According to the available data from 31 countries, a total of 42 per cent of women who were physically and/or sexually abused by a partner experienced physical injuries as a result. Globally, 7.2 per cent of adult women have experienced sexual violence by a non-partner.[20]

52. Violence against women touches the lives and livelihoods of women everywhere. It negatively affects women's health, impedes their ability to participate fully in society, affects their enjoyment of sexual and reproductive health rights and, in many cases, denies them these rights, resulting in severe physical and mental effects that have an impact on both women and their families.

53. Violence against women and girls manifests in numerous forms, which include witchcraft- and dowry-related violence and deaths; crimes committed in the name of so-called "honour femicide"; domestic violence; and harmful practices, such as child and forced marriage, and female genital mutilation. It also includes sexual violence and diverse forms of it, such as forced sterilization; forced nudity; forced or denied abortions; sexual harassment; and incest and rape, including marital rape and gang rape.[21] In many States, laws and policies prevent women from having equal access to land, property and housing. Economic and social discrimination limits the quality and availability of life choices, making them vulnerable to trafficking.

54. However, specific groups of women affected by various forms of discrimination, such as women with disabilities, migrant women and lesbian, bisexual and transgender women, are particularly vulnerable to violence. For example, lesbian women face violence based on

[19] OHCHR, "UN expert: at time of crisis, we must guarantee water and sanitation for all," 2 November 2020.

[20] WHO, London School of Hygiene and Tropical Medicine, and South African Medical Research Council, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence* (Geneva, WHO, 2013).

[21] OHCHR, *Information Series on Sexual and Reproductive Health and Rights: Violence against Women*. Available at www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_VAW_WEB.pdf.

their sexual orientation or gender identity. Both the Committee on the Elimination of Discrimination against Women and the Special Rapporteur on violence against women have expressed concern about the occurrence of rape targeting lesbian women with the intention of “curing” them of their sexual orientation.[22]

55. The Special Rapporteur asserts that the term “corrective rape” is wrong and that “homophobic rape” better locates the violence on the person, and particularly lesbian women, based on their sexual orientation. She rejects the idea that there is something fundamentally wrong and hence needing correction. It is important to also recognize sexuality-based violence to ensure that the right to health protections are not solely focused on a person’s gender. Another issue of concern refers to women and girls with disabilities who are particularly exposed to forced sterilization, especially when they have intellectual disabilities.[23]

56. According to a recent report of the International Lesbian, Gay, Bisexual, Trans and Intersex Association, 69 countries still criminalize consensual same-sex relationships between adults.[24] In the light of the statistics outlining violence against women noted above, the impact of this criminalization on lesbian and transgender women who experience homophobic rape and other forms of sexual violence is that when they are raped or abused, they are denied adequate medical and legal assistance owing to the prejudices in law and practice that are already held against them.

57. One of the previous mandate holders explained that legislation criminalizing same-sex consensual activity violated the realization of the right to health because it deterred those engaging in consensual same-sex conduct from seeking out and gaining access to health services.[25] Lesbian, gay, bisexual, transgender and intersex persons are disproportionately affected by intersectional discrimination in the context of sexual and reproductive health. Where available, gender-affirming treatment is often very expensive, and public or private health insurance coverage is usually not available. Many individuals within this group, including adolescents, are deterred from approaching health-care workers out of fear of judgmental attitudes linked to social norms that stigmatize their sexual behaviour.

58. On the other hand, health-care workers are often not trained to meet the needs of lesbian, gay, bisexual and transgender persons, not only in terms of sexual health, but also regarding their general health. It is not uncommon that health-care workers refuse to treat them altogether, or respond with hostility when compelled to do so, with attitudes ranging from public humiliation, verbal abuse or psychiatric evaluations, to a variety of coerced procedures. The latter can include forced sterilization, State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities, and invasive virginity examinations. In other cases, they are subjected to hormone therapy and genital normalizing surgeries under the guise of so-called “reparative/conversion therapies”. These medical procedures are hardly ever medically necessary, and they can cause scarring, loss of sexual sensation, pain, incontinence and lifelong depression. Such procedures may also be unscientific, harmful and, in all cases, contribute to stigma.[26]

59. Since 2011, the Human Rights Council has adopted several resolutions on human rights, sexual orientation and gender identity. While relevant violations linked to sexual orientation and gender identity have been addressed by the mandate since its establishment, the first Council resolution on this particular subject, adopted in 2011, paved the way for the first comprehensive United Nations report on the subject. The report presented evidence of a pattern of systematic violence and discrimination directed against lesbian, gay, bisexual,

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[22] See, for example, CEDAW/C/ZAF/CO/4, para. 39; and A/HRC/32/42/Add.2, paras. 33–34.

[23] A/HRC/20/5, para. 22.

[24] International Lesbian, Gay, Bisexual, Trans and Intersex Association, *State-Sponsored Homophobia: Global Legislation Overview Update* (Geneva, December 2020); and OHCHR, *Information Series on Sexual and Reproductive Health and Rights: Lesbian, Gay, Bisexual, Transgender and Intersex Persons* (2020).

[25] A/HRC/14/20, para. 18.

[26] A/HRC/22/53, para. 76.

transgender and intersex persons in all regions. In 2016, a mandate to specifically deal with these matters was created.

60. Women human rights defenders are also targeted by State power and are ostracized by their communities as they are seen as threats to culture and religion. For example, at its seventy-ninth session, the Working Group on Arbitrary Detention noted with concern the arbitrary detention, harassment and torture, reportedly by law enforcement authorities, of a Ugandan woman human rights defender working on women's rights and the rights of lesbian, gay, bisexual, transgender and intersex people, for being highly critical of the President on social media.[27]

61. At the International Conference on Population and Development in 1994, States recognized the need to eliminate all forms of violence against women and committed to take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children.[28] Similarly, the Beijing Declaration and Platform for Action established that women's rights include their right to sexual and reproductive health, free of coercion, discrimination and violence.

62. In 2013, the Commission on the Status of Women held its fifty-seventh session, at which it focused on the elimination and prevention of all forms of violence against women and girls. At that session, the Commission recognized the short- and long-term adverse consequences of violence against women on their sexual and reproductive health rights. The Commission underscored that protecting and fulfilling reproductive rights was a necessary condition to achieving gender equality and the empowerment of women in order to enable them to enjoy all their human rights and fundamental freedoms, and to prevent and mitigate violence against women.[29]

63. The Special Rapporteur agrees with the Special Rapporteur on violence against women, its causes and consequences, that the prevention of gender-related killings and the investigation and sanctioning of violence requires a holistic approach in all the measures taken by States, particularly in designing, implementing and evaluating legislation and policies. Such an approach encompasses: promoting societal transformation, including the eradication of harmful stereotypes; developing information systems and good quality data on gender-motivated killings; ensuring adequate enforcement by police and the judiciary of civil remedies and criminal sanctions; and ensuring an adequate provision of legal, social and health-care services for women victims of violence.[30]

64. In its resolution 275, on protection against violence and other human rights violations of persons on the basis of their real or imputed sexual orientation or gender identity, the African Commission on Human and Peoples' Rights strongly urged States to end all acts of violence and abuse, whether committed by State or non-State actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence, including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.[31]

C. Sexual and reproductive health rights

65. In its general comment No. 22 (2016) on the right to sexual and reproductive health, the Committee on Economic, Social and Cultural Rights clarified that the right to sexual and reproductive health is an integral part of the right to health. However, a plethora of structural and systemic issues prevent all persons from freely and fully enjoying these rights. These barriers are not only interrelated but also entrenched in many societies at different levels, including clinical care, at the level of health systems, and in the underlying and social

[27] See A/HRC/WGAD/2017/57.

[28] International Conference on Population and Development, *Programme of Action*, Cairo, 5–13 September 1994 (A/CONF.171/13/Rev.1), para. 4.9.

[29] *Official Records of the Economic and Social Council, 2013, Supplement No. 7* (E/2013/27), para. 22.

[30] See A/HRC/20/16.

[31] African Commission on Human and Peoples' Rights, resolution 275 (ACHPR/Res.275(LV)2014).

determinants of health. These barriers are further intersectional and determine whether or not an individual will have a negative health outcome or a positive one.

66. Under the right to health framework, States have an obligation to respect, fulfil and protect the right to sexual and reproductive health, including in relation to contraception and family planning. Violations of the obligation to respect the rights to sexual and reproductive health include criminalization of women undergoing abortions; the criminalization of consensual sexual activity between adults; banning or denying access in practice to sexual and reproductive health-care services and medicines, including as a result of discrimination based on race or ethnic origin;[32] and the prescription of involuntary, coercive or forced medical interventions – e.g., in the case of forced sterilization of women with disabilities or women from minority or indigenous groups.

67. Banning or denying access in practice to contraceptives, including based on the lack of authorization by a woman's husband, partner, parent or health authority, or because a woman is unmarried, also constitutes a violation of the rights to sexual and reproductive health. States are obliged to take measures to prevent third parties from interfering with the rights of individuals to sexual and reproductive health and to ensure that third parties do not limit women's access to contraceptives and family planning information and services.

68. States also have the obligation to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realization of the rights to sexual and reproductive health, including those related to contraception, and to ensure access to information and a wide range of contraceptive methods, such as condoms and emergency contraception; medicines for abortion and for post-abortion care; and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV.[33]

69. This, above all, should guide all engagement around access to sexual and reproductive health rights. Dignity and bodily autonomy are central to them and therefore States should incorporate human rights-oriented decision-making into all legislative, administrative, budgetary, judicial and other measures regarding the rights to sexual and reproductive health.

70. The Special Rapporteur, cognizant of the pre-existing barriers that prevent the free and full enjoyment of the right to health, will build on the work already done by her predecessors and continue to examine the following sub-themes as part of the realization of sexual and reproductive health rights.

1. Impact that criminalization and other legal restrictions continue to have on abortion, conduct during pregnancy, contraception and family planning, and the provision of sexual and reproductive education and information

71. The Special Rapporteur aims to conduct a thorough appraisal of existing legal and policy restrictions to highlight their discriminatory nature and the impact they have on the enjoyment of the right to health. Criminalization is an affront to the individual's right to health, particularly with respect to decision-making and bodily integrity. It undermines one's human dignity and further creates public health outcomes that are negative, disproportionately affecting persons capable of getting pregnant.[34]

2. Criminalization of consensual sex between adolescents of similar ages

72. Sexual activity among adolescents is widespread, although rates vary significantly. However, many countries continue to adopt punitive approaches to the sexual activity of adolescents, which further stigmatize, demonize and discriminate against them. The healthy sexual development of adolescents requires both physical maturation and an understanding of healthy sexual behaviours, as well as a positive sense of sexual well-being. Punitive

[32] For example, the Committee on the Elimination of Racial Discrimination expressed concern about the discriminatory treatment and verbal and physical violence faced by Roma women when accessing sexual and reproductive health services and about the lack of reparation for Roma women who have been subjected to forced sterilization in Slovakia (CERD/C/SVK/CO/11-12, para. 23).

[33] Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 13.

[34] See A/66/254.

approaches to consensual sex between adolescents of a similar age poses significant barriers for them to access the information, services and goods needed to protect their sexual and reproductive health.

73. As already highlighted by the previous mandate holder, adolescents have the right to be provided with the tools and information to navigate sex safely.[35] States should therefore adopt a comprehensive gender-sensitive and non-discriminatory sexual and reproductive health policy for all adolescents and to integrate it into national strategies and programmes. The policy must be consistent with relevant human rights standards and recognize that unequal access by adolescents constitutes discrimination. The Special Rapporteur plans to build on her predecessors' reports on the right to health of adolescents and on the criminalization of same-sex conduct and sexual orientation, sex work and HIV transmission, through the lens of substantive equality and intersectionality.

3. Sex workers

74. In April 2020, the Joint United Nations Programme on HIV/AIDS (UNAIDS) called upon countries to take immediate, critical action, grounded in human rights principles, particularly during the COVID-19 pandemic, to protect the health and rights of sex workers.[36] The Special Rapporteur seconds this call and agrees that health crises such as the COVID-19 pandemic expose existing inequalities, disproportionately affecting those who are already criminalized, in marginalized or vulnerable situations, or living in financially precarious situations, usually outside social protection mechanisms.

75. In a report on deprivation of liberty and the right to health, the previous mandate holder referred to restrictions on the liberty of movement that have appeared over the last 200 years as a tool of social control, often used as a default, to promote "morals", public safety and public health. He highlighted the existence of punitive legal frameworks and public policies that lead to the detention of individuals on the grounds of behaviours, identities or status socially labelled as "immoral". They include sex work, sexual orientation and gender identity, drug use, HIV status, non-adherence to tuberculosis treatment and exposure to infectious diseases, and health-care services needed only by women, such as abortion. Incarceration linked to those types of behaviour hinders the realization of the right to health.[37]

76. In another previous report under the mandate, it was noted that criminalization of sex work was often justified as a means to protect public morality and decency and that sex workers were often faced with harassment by the police in the form of moral punishment.[38]

77. The Special Rapporteur plans to further explore the concept of morality as linked to sex work. She agrees with the Sexual Rights Initiative and Global Network of Sex Work Projects[39] in that morality is central to controlling sexuality by considering it deviant, and constitutes a holdover from colonial conquest, which sought to control people as a whole. Colonialism made morality a commodity possessed by colonial powers, which was subsequently used to found nationhood and which is underpinned by norms and values applied to subjects that are marginalized in relation to sexuality and gender. The effect of conservative morality has been discussed as it pertains to same-sex relations but less in relation to the construction of women's sexuality and the impact on relevant laws and policies.

D. Innovation and digital technology: sexual and reproductive health rights, digital interventions and tele-health

78. Technological developments in health care have proven to be an instrumental element in the provision of health care and have improved our quality of life. Innovation and digital

[35] A/HRC/32/32, para. 83.
[36] UNAIDS, "Sex workers must not be left behind in the response to COVID-19", 8 April 2020.
[37] A/HRC/38/36, paras. 8 and 19.
[38] A/HRC/14/20, paras. 4 and 42.
[39] Sexual Rights Initiative and Global Network of Sex Work Projects, submission of October 2018 to the Working Group on discrimination against women and girls, para. 5.

technology have improved our ability to store, share and analyse health information. They have also increased provider capabilities and improved patient access to health-care services, all of which have been instrumental to, inter alia, handling the COVID-19 pandemic.

79. Therefore, because innovation and digital technology are going to keep transforming health care more than any other force, it is important that more investment be directed towards improving innovation and digital technology. Universal access to health-care services is not possible without policies to ensure affordable access to health technologies. There are, however, legitimate concerns about the human rights abuses digital technology can enable in the area of health care.

80. The Special Rapporteur notes the youth-centred digital health interventions, an inter-agency framework developed by WHO, the United Nations Children’s Fund, the United Nations Population Fund and the United Nations Educational, Scientific and Cultural Organization. It provides guidance and principles on effective planning, development and implementation of digital solutions with and for young people to address the many health challenges they may face as they grow into adulthood. It draws on the experience of many organizations and individuals working in the field – including young people themselves – and builds on existing knowledge and tools.

81. With this in mind, the Special Rapporteur will attempt to champion digital health-care solutions while advocating for constant vigilance and accountability regarding the mechanisms that drive the technology in order to ensure equitable, non-discriminatory access for all.

82. Factors that need attention in the execution of equitable digital health include accessibility and affordability. The digital divide in much of the global South and in other developing contexts still excludes many from what has been referred to as the fourth industrial revolution. As highlighted in a report of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, emerging digital technologies exacerbate and compound existing inequities, many of which exist along racial, ethnic and national origin grounds.[40] This is a serious consideration in the light of the well-established evidence for racism that is so deeply embedded in the global health-care system in that it makes digital health-care solutions susceptible to absorbing those same faults.

83. A specific illustration of these points was also provided in the above-mentioned report. A study on health-care algorithms showed how Black patients in the United States were assigned lower risk scores than white patients, despite being equally sick, hindering Black patients from being referred for health-care interventions.[41]

84. Digital surveillance, monitoring and facial recognition in technologies that are being used in health innovations may perpetuate racism, thereby embedding it in health technology. If left unchecked and unchallenged, these interventions will likely lead to artificial intelligence in health programmes that continue to be racist. These advancements are not neutral and the discrimination can lead to unjust outcomes to diagnostics, investigations, analytics and algorithms.

85. The cost of accessing information is often unachievable for impoverished people. To this end, digital health and self-managed care must go hand in hand with subsidized or zero-rated data access to ensure that all people, regardless of economic status can enjoy the highest attainable standard of health, in all forms, including digital.

86. Within the Special Rapporteur’s mission to employ non-discrimination, anticoloniality and intersectionality in fulfilling her mandate, it must be noted that digital solutions must go beyond technology and that they are not neutral. She agrees that digital and artificial intelligence solutions can be rules-based, open, commercialized or authoritarian, and that they can build on the involvement of citizens, communities and patients, or can be focused on health professionals only. There is a need to understand how uneven distribution, uneven quality, different levels of acceptance in different cultures, and different governance

[40] A/HRC/44/57, para. 4.
[41] Ibid., para. 30.

models affect successful application. In order to achieve impact and ensure rights, it is essential to think beyond the technology.[42]

E. Racism and the right to health

87. In 2018, Charles Ngwena noted:

> It hardly needs to be stressed that race commands an existential, durable presence as a social construction that is materially real in political, economic and cultural senses. ... Race remains an associational criterion that people often claim as part of their identity or that may be ascribed to them by others or the political community of which they are part. Race has political implications where the body politic is racialized, overtly or covertly, in the sense that racial differentiation is tethered to hierarchized essences that carry social, political and economic meanings that may be positive or negative for the racialized subject, depending on which side of the "colour line" the person falls or is deemed to fall.[43]

88. The same perspective can be extended to ethnicity to say that ethnicity has political implications where the body politic is ethnicized, overtly or covertly, in ways that carry social, political and economic meanings that may be positive or negative for the ethnicized subject. Indigenous peoples' concept of health is frequently disregarded within non-indigenous health systems, creating significant barriers to access.[44] Indigenous peoples worldwide experience higher rates of health risks, poorer health outcomes and greater unmet needs in respect to health care than their non-indigenous counterparts.

89. With above propositions in mind, it can be understood that people of African descent are socially positioned to experience multiple forms of systemic oppression. These systems, which occur simultaneously, disproportionately affect people of African descent, increasing, inter alia, their susceptibility to COVID-19. These systems are anchored in discriminatory practices and systematically distribute resources, power and opportunities along racial lines, thereby preventing all people, especially people of African descent, from fully and freely participating in society, governance and the economy. In terms of the right to health, systemic racism manifests itself through differential access to both health care and the underlying determinants of health.

90. It has been largely documented that racism leads to increased rates of mortality and morbidity.[45] Therefore, in order to comprehensively address the systemic racism embedded in global health, an intersectional approach must be employed because race interacts with other social locations, including gender; sexual orientation; level of education; and economic, disability or other status, to determine an individual's access to health care.

91. Intersectionality requires an understanding of the impact of racial and gendered oppression and its manifestations. For example, women of African descent often: have difficulty accessing modern contraception methods;[46] have experiences of pain management that are poor; and have insufficient or no access to adequate prenatal and pregnancy care. Compared with their white counterparts, more Black women die from preventable maternal-related conditions and birthing complications, and neonatal deaths are more prevalent in

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[42] The Lancet and Financial Times Commission, "Growing up in a digital world", 2019. Available at www.governinghealthfutures2030.org/wp-content/uploads/2019/10/Two-page-Commission-brief.pdf.

[43] Charles Ngwena, *What is Africanness?: Contesting Nativism in Race, Culture and Sexualities* (Pretoria, Pretoria University Law Press, 2018).

[44] A/HRC/30/41, para. 31.

[45] See, for example, Mohammad S. Razai et al., "Mitigating ethnic disparities in covid-19 and beyond", *The BMJ*, vol. 372 (15 January 2021); Sharrelle Barber, "Death by racism", *The Lancet Infectious Diseases*, vol. 20, issue 8 (1 August 2020); Michelle A. Albert et al., "Perceptions of race/ethnic discrimination in relation to mortality among Black women: results from the Black women's health study", *Archives of Internal Medicine*, vol. 170, No. 10 (24 May 2010).

[46] Jennifer S. Barber et al., "Contraceptive Desert? Black-White Differences in Characteristics of Nearby Pharmacies", *Journal of Racial and Ethnic Health Disparities*, vol. 6 (20 February 2019).

Black children.[47] In addition, Black women lack or have inadequate access to domestic violence assistance and to adequate wages to support their families.

92. In reality, the ability to make a choice is not enough for many women and girls of African descent; their right to bodily autonomy and integrity and to make decisions about whether to have children, or whether a pregnancy is supportable and can be carried to term, depend on other factors, such as the possibility for them to secure their children's right to a standard of living that is adequate for their physical, mental, spiritual, moral and social development.

93. Racism and its influence in the spatial planning of towns and cities have resulted in many people of African descent and their communities living in areas that have high levels of air, land and water pollution due to industrial activities. High-density spaces lead to poor ventilation and to higher rates of chronic illness, all of which have served to increase the severity of disease and rates of mortality in the context of the COVID-19 pandemic.

94. An important intersection to consider when examining the many manifestations of racism and gender is the convergence of race and sport and its impact on physical and mental health. Historically, athletes and sports figures of African descent have faced gruelling and at times unfair interrogation about their abilities, and have been subjected to much harsher application of the rules in their respective sports. This observable pattern is worth noting when considering the extent to which racism infiltrates sport and other institutions, affecting the lives of Black people at different levels of society.

F. Health equity

95. All people have a fundamental need for health care, yet inequalities in health status and access to health-care services persist. As a result of broader social and economic issues, individuals who are marginalized because of poverty, gender, ethnicity, social norms, or stigma and discrimination experience negative health outcomes. Medical interventions are not the main determinants of health. Health outcomes are rather determined by underlying and social factors, including nutrition, housing, work environment, education, discrimination, violence, and the presence or absence of war, among others.

96. In order to achieve health equity, it is necessary to eliminate structural and systemic barriers to accessing health-care services, goods and facilities. Such barriers include poverty and discrimination, and their consequences, such as powerlessness and lack of access to: good jobs with fair pay; quality education; housing; and safe environments.

97. In 2005, WHO established the Commission on Social Determinants of Health to address the social factors leading to ill-health and health inequities. The Commission delivered its final report to WHO in July 2008. Its overarching recommendations were to improve living conditions; to tackle the inequitable distribution of power, money and resources; and to assess the impact of actions by measuring the problem.

98. In a report on the critical role of the social and underlying determinants of health in advancing the realization of the right to mental health, the previous mandate holder reiterated that the right to health is not the right to be healthy, but a right to both conditions and services that are conducive to a life of dignity and equality, and non-discrimination in relation to health.[48] To the most commonly listed preconditions for individual health – food, housing, education and work – he added the psychosocial elements that promote individual and social well-being.

99. The quality of connections between individuals, families and communities over the course of life, across generations, between government and people, between different nations and between humankind and nature, are critical for mental health. In turn, these relationships are shaped by the socioeconomic, political and cultural structures in homes, schools,

[47] Brad N. Greenwood et al., "Physician–patient racial concordance and disparities in birthing mortality for newborns", *Proceedings of the National Academy of Sciences*, vol. 117, No. 35 (17 August 2020).

[48] A/HRC/41/34, para. 11.

workplaces, health-care settings and the community, and they are affected by issues, including abusive relationships, violence and social disparities, among others.

100. The COVID-19 pandemic has already been shown to be a fairground of inequality threatening the integrity of the roll-out processes of COVID-19 vaccines. In this context, the Committee on Economic, Social and Cultural Rights has underlined the right of everyone to enjoy the benefits of scientific progress. The Committee stresses that pandemics are a crucial example of the need for scientific international cooperation to face transnational threats. Viruses and other pathogens do not respect borders. Combating pandemics effectively requires stronger commitment from States to scientific international cooperation, as national solutions are insufficient. If a pandemic develops, sharing the best scientific knowledge and its applications, especially in the medical field, becomes crucial to mitigate the impact of the disease and to expedite the discovery of effective treatments and vaccines.[49]

101. Unfortunately, it seems that some Governments have secured vaccines for their citizens only.[50] Health policies and procurement procedures that are isolationist in nature are inconsistent with international human rights standards. Some have expressed concerns that countries with more financial resources have been signing deals for preferential access to COVID-19 vaccines, which risks leaving other countries behind. WHO and others have warned about the dangers of supply and vaccine nationalism. In a statement made at the meeting of the Council for Trade-Related Aspects of Intellectual Property Rights of the World Trade Organization held in July 2020, South Africa stated that world leaders from the north and south had referred to vaccines as a global public good that should be fairly and equitably available globally, leaving no one behind, and that the time to put that premise into action was now.[51]

102. The Committee on Economic, Social and Cultural Rights has reiterated[52] that every person has a right to have access to a COVID-19 vaccine that is safe, effective and based on the application of the best scientific developments. Therefore, as also reiterated by the Committee, States have an obligation to take all the measures necessary, to the maximum available resources, to guarantee access to these vaccines to all persons without discrimination and as expeditiously as possible. States further have the obligation to avoid unjustified discrimination and inequalities in such access and to equally ensure universal and equitable access to treatment for COVID-19.

103. This is particularly relevant to those in vulnerable situations who are frequently neglected in terms of health care, including people living in poverty; women; indigenous peoples; persons with disabilities; older persons; minorities; internally displaced persons; persons in overcrowded settings and in residential institutions; people in detention; homeless persons; migrants and refugees; people who use drugs; and lesbian, gay, bisexual, transgender and gender-diverse persons.

104. The benefit of industry and private companies cannot be prioritized over the rights to life and health of billions, in particular with such far-reaching consequences. The Committee has also stressed that, while private business entities receive a reasonable compensation for their investments and research in vaccines, they should also refrain from invoking intellectual property rights in a manner that is inconsistent with the right of every person to access a safe and effective vaccine for COVID-19.[53] In this regard, vaccine roll-out programmes must make sure that no one is left behind, for the benefit of humanity as a whole.

[49] E/C.12/2020/1, para. 23. See also E/C.12/2020/2.

[50] OHCHR, "Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world", 9 November 2020.

[51] Statement of South Africa at the meeting of the Council for Trade-Related Aspects of Intellectual Property Rights of the World Trade Organization of 30 July 2020. Available at www.keionline.org/33593.

[52] E/C.12/2020/2.

[53] E/C.12/2021/1.

G. Non-communicable diseases: reproductive cancers

105. WHO has set out to eliminate cervical cancer by 2050 in an attempt to avoid the deaths of millions of women and girls. The strategy, backed by WHO member States at the World Health Assembly 2020, involves vaccinating 90 per cent of girls by the age of 15; screening 70 per cent of women by the age of 35, and again by the age of 45; and treating 90 per cent of women identified with cervical disease. Figures from 2018 indicate that 570,000 women were diagnosed with cervical cancer and 311,000 died. If it is not stopped, annual case numbers are projected to reach 700,000, with 400,000 associated deaths, by 2030.[54]

106. The current availability of vaccines for the human papillomavirus – the cause of cervical cancer – are skewed towards wealthier countries and, as with COVID-19, States need to show solidarity to ensure that everyone has equitable access to affordable vaccines and the artificial intelligence technology to screen for cervical cancer.

107. As per the focus of the Special Rapporteur's approach to ensuring delivery of the right to the highest attainable standard of health for all, the principles of non-discrimination, anti-racism and intersectionality will be highlighted as a way to guide States' commitment to solidarity in providing the vaccines and screening technology needed to end cervical cancer.

108. As part of her priorities, the Special Rapporteur is considering analysing progress in and challenges to achieving the Sustainable Development Goals in the last decade. She is also considering an analysis of the role of the determinants of health – including climate change and environment, water and sanitation, education and gender equality – and the role of partnerships, hierarchy and the United Nations in this process.

109. Finally, the Special Rapporteur is considering an examination of the role played by the privatization of health-care services – including public-private partnerships, financial aid and philanthropy – in attaining universal health coverage.

V. Conclusions

110. **Although advancements in health-care technologies have contributed to better health outcomes over the last few decades, the inequities embedded in public health systems have created incomplete and inadequate access to the benefits of said advancements. Too many people have been and continue to be left behind, owing to the reluctance of societies to identify and name oppressive systems of social organization.**

111. **Based on the groundbreaking contributions of the previous mandate holder – who broadened the understanding of autonomy and human rights in the context of adolescents, among others – it can be said that the mandate's influence on human rights-centred policy is well established. The Special Rapporteur hopes to continue expanding this influence on realizing the right to health by providing insights on how to continue contributing to the full realization of the right to health using available opportunities to address the challenges currently faced.**

112. **In striving towards realizing the right to health for all, approaches that take the plurality of human experiences into account must remain a priority of States in their endeavours to respect, fulfil and protect the right to health for all.**

113. **Equality must be understood in the context of the historical injustices that necessitate them. Solutions aimed at achieving equality, therefore, cannot be ignorant to the position within the social power matrix of the people they want to serve.**

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[54] WHO, *Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem* (Geneva, 2020).