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**IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 60/251
OF 15 MARCH 2006 ENTITLED “HUMAN RIGHTS COUNCIL”**

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

Addendum

MISSION TO SWEDEN*

* The summary of this mission report is being circulated in all official languages. The report itself, contained in the annex to the summary, is being circulated in the language of submission only.

Summary

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to the highest attainable standard of health” or “right to health”) visited Sweden from 10 to 18 January 2006. The key objectives of the mission were to understand how the Government of Sweden endeavours to implement the right to the highest attainable standard of health at the national and international levels.

The Special Rapporteur held meetings with government representatives, civil society organizations and health professionals in Stockholm, Jokkmokk and Malmö.

The standard of living, health status and quality of health care in Sweden are among the best in the world. As well as its commitment to guaranteeing good health at the national level, the Government makes important contributions through its foreign policies to realizing the right to health and the health-related Millennium Development Goals in developing countries.

Following the Introduction, section II of this report signals Sweden’s obligations regarding the right to health under international human rights law. Section III considers how these international obligations are given effect at the national level through domestic legal, policy and institutional frameworks. While Sweden has ratified many international treaties recognizing the right to health, this human right is less firmly entrenched in Sweden’s domestic laws and policies. A major challenge is to integrate the right to health into domestic policymaking processes.

Section IV gives attention to some key domestic issues with a bearing on the right to health, including: access to appropriate health care; mental health; the Sami; an integrated harm-reduction policy for drug users; human rights education for health professionals; asylum-seekers and undocumented foreign nationals; and foreign nationals with life-threatening conditions.

Section V focuses on Sweden’s foreign policies and their relationship to the right to health in developing countries. To its credit, Sweden has committed to mainstreaming human rights in its foreign policies. The Special Rapporteur begins to consider the degree to which human rights have been brought to bear upon all aspects of Sweden’s foreign policy, and to what degree they are taken into account in practice.

Section VI encourages the introduction of a human rights-based approach to health indicators, the disaggregation of health data on various grounds of discrimination, and the integration of the right to health into impact assessments.

Annex

**REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE
TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF
PHYSICAL AND MENTAL HEALTH, PAUL HUNT, ON HIS MISSION TO
SWEDEN (10-18 JANUARY 2006)**

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I. INTRODUCTION

1. At the invitation of the Government, the Special Rapporteur visited Sweden from 10 to 18 January 2006. The purpose of the mission was to assess, in a spirit of cooperation and dialogue, how Sweden seeks to realize the right to the highest attainable standard of health at the domestic and international levels.

2. The key themes of the mission were the impact of poverty and discrimination, including inequalities, on the enjoyment of the right to the highest attainable standard of health in Sweden. The Special Rapporteur also addressed Sweden's foreign policies, in particular its international development assistance, and their impact on the right to the highest attainable standard of health in developing countries. He considered the implementation of the right to health with a view to assisting the Government - and other relevant actors - in their efforts to address the challenges and obstacles to its realization.

3. The agenda for the Special Rapporteur's visit was arranged in close cooperation with the Ministry of Health and Social Affairs and the Ministry of Foreign Affairs. Throughout the mission, all levels of Government - central, regional and local - were constructive and open. The Special Rapporteur is grateful for the valuable cooperation and assistance he received before, during and after the mission.

4. During his mission, the Special Rapporteur met with representatives from the Ministry of Health and Social Affairs, including the Minister for Health, Ms. Ylva Johansson; representatives of the Ministry of Foreign Affairs, including the Minister for International Development, Ms. Karin Jamtin, and the Minister for Migration and Asylum Policies, Ms. Barbro Holmberg; and representatives of the Ministry of Justice and the Swedish International Development Cooperation Agency (Sida). He further met representatives of the Swedish National Institute for Public Health and the National Board of Health and Social Welfare. The Special Rapporteur held discussions with the Ombudsman against ethnic discrimination, Ms. Katri Linna, and the Ombudsman on disability, Mr. Lars Lööv.

5. In Malmö, the Special Rapporteur held meetings with representatives of the University Hospital, local government and civil society, as well as with health professionals. In Jokkmokk, he met the President of the Sami Parliament in Sweden, Mr. Lars-Anders Baer, representatives of the Norwegian Sami Parliament and representatives of local authorities and civil society.

6. The Special Rapporteur had the opportunity to meet with representatives of numerous civil society organizations, including non-governmental organizations and national medical associations, working on issues related to the right to health in Sweden. He also met with organizations working on issues related to Sweden's international development and trade policies.

7. The Special Rapporteur expresses his sincere thanks to all those whom he met for their excellent cooperation.

An overview of health status in Sweden and introduction to the issues covered by this report

8. Swedes tend to enjoy a standard of living, life expectancy and health status that is among the best in the world. In 2003, life expectancy was 82.4 years for women and 77.9 years for men.¹ Sweden's health system attracts considerable resources and is recognized as one of the nation's vital social institutions. To its credit, the Government also attaches a high priority to human rights, such as the right to the highest attainable standard of health, in its international policies.

9. Moreover, there have been significant improvements in many health outcomes in Sweden. Between 1970 and 2002, infant mortality fell from 11 to 3 deaths per 1,000 live births. Deaths on account of traffic accidents, work-related deaths and injuries, and the number of daily smokers have also fallen significantly in recent years. Recently, cardiovascular diseases have also become less prevalent.²

10. This is the impressive general context within which this report has to be understood. The following paragraphs also signal some of the specific, commendable health policies and practices that are a credit to the Government of Sweden.

11. However, there is no room for complacency. There are some worrying health trends in Sweden. Rates of mental health problems, for example, have increased significantly in recent years, as has obesity. Since the 1990s, reported cases of chlamydia have significantly increased, and there have been increasing rates of infection of other sexually transmitted infections - particularly among youth - including gonorrhoea and syphilis. Cases of HIV are also increasing.³ Examined through the prism of the right to health, some health policies are a cause for genuine concern.

12. This report focuses on a selection of key national and international issues arising from the right to the highest attainable standard of health, especially those associated with poverty and discrimination. At the national level, the selected issues include: key legislative, policy and institutional frameworks; the challenge of mainstreaming the right to health across all health-related policies; access to health care, including for marginalized groups; the right to health of Sami, asylum-seekers and undocumented foreign nationals; mental health; human rights education for health professionals; and the need for an integrated and comprehensive harm-reduction policy for intravenous drug users.

¹ The statistics, and other information, in this and the following paragraph are found in A. Glengard et al., *Health in Transition: Sweden*, WHO, 2005.

² However, cardiovascular diseases remain the leading cause of mortality, accounting for nearly half the deaths in 2001. Cancer is the second leading cause of death.

³ Glengard, op. cit.

13. The report also considers how Sweden endeavours to give effect, at the international level, to the right to the highest attainable standard of health. Thus, it considers the mainstreaming of the right to health across Sweden's international policies and how the right is operationalized in Swedish international development cooperation.

14. Importantly, while remaining within the 10,700-word limit for reports, it is impossible to give attention to all the important national and international issues arising from Sweden's right to health obligations, such as the special issues concerning the ageing population, alcohol abuse, obesity, domestic violence,⁴ sick leave, and health care for the prison population.

II. INTERNATIONAL LEGAL FRAMEWORKS FOR THE RIGHT TO HEALTH

15. Sweden has ratified a range of international human right treaties recognizing the right to health and other health-related rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of all Forms of Racial Discrimination, the Convention on the Elimination of All Forms Discrimination Against Women, and the Convention on the Rights of the Child. It has also ratified regional human rights treaties such as the Convention on Human Rights and Fundamental Freedoms (European Convention on Human Rights), the revised European Social Charter and the European Convention on Social and Medical Assistance.

16. Further, Sweden has ratified the second Additional Protocol to the European Social Charter Providing for a System of Collective Complaints (1995). While the Government recognizes the right of national and international employers and trade unions, and other international non-governmental organizations (NGOs), to make collective complaints under this protocol, it has not yet recognized the right of other NGOs within Sweden to do so.⁵ **The Special Rapporteur encourages the Government to recognize the competence of NGOs within Sweden other than trade unions and employers' organizations to make such complaints. This will help enhance accountability for the right to health in Sweden. He also encourages the Government to support the drafting of an optional protocol to ICESCR which will enhance accountability for this human right both in Sweden and in other jurisdictions.**

17. The Special Rapporteur notes with satisfaction that Sweden is examining the possibility of ratifying the ILO Indigenous and Tribal Peoples Convention, 1989 (No. 169). **He encourages the Government to ratify this Convention as soon as possible. The Special Rapporteur also**

⁴ The Special Rapporteur notes that the Special Rapporteur on violence against women also undertook a mission to Sweden in 2006. The Special Rapporteur on the right to health has sent his findings on the right to health implications of violence against women in Sweden to the Special Rapporteur on violence against women for her consideration.

⁵ Additional Protocol to the European Social Charter Providing for a System of Collective Complaints (1995), art. 2.

encourages the Government to consider ratifying the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

18. The ratification of international and regional human rights treaties gives rise to obligations which are binding under international law. However, an international treaty obligation has the force of law in Sweden only when it is incorporated into national law. At present, besides Regulations which are issued by EU institutions and immediately applicable in Sweden, only the European Convention on Human Rights has been incorporated into Swedish law. **With a view to improving protection of the right to health in Sweden, the Special Rapporteur urges the Government to incorporate international and regional treaties protecting the right to health into domestic law.**

III. DOMESTIC LEGAL, POLICY AND INSTITUTIONAL FRAMEWORKS FOR THE REALIZATION OF THE RIGHT TO HEALTH AT THE NATIONAL LEVEL

A. Domestic legal framework

19. Chapter II of the Instrument of Government (*Regeringsformen*), which forms part of Sweden's Constitution, is entitled Fundamental Rights and Freedoms. Regrettably, it does not enshrine the right to health. However, chapter I of the Instrument, "Principles for Public Life", recognizes that "The personal, economic and cultural welfare of the private person shall be fundamental aims of public activity. In particular, it shall be incumbent upon the public institutions to secure the right to health, employment, housing and education, and to promote social care and social security."⁶

20. A number of domestic laws set out health-care related responsibilities of various authorities. Of central relevance is the Health and Medical Services Act, which establishes that the goals of health and medical services are to assure the entire population good health on equal terms, and that care should be prioritized according to need.⁷ The Act stipulates that county councils have responsibility for providing health care, health promotion and disease prevention.⁸ The Act also establishes that municipalities have health-related responsibilities for particular groups, for example they have responsibilities for providing habilitation, rehabilitation and assistive devices for persons with disabilities, care for the elderly, childcare, and support for persons in sheltered accommodation. **The Special Rapporteur was concerned about reports of unsatisfactory coordination between the counties and municipalities with respect to health care and related support services. He urges central, county and municipal authorities to take steps to improve coordination, with a view to the better protection of the right to health and implementation of the goals of the Health and Medical Services Act.**

⁶ Instrument of Government (SFS No. 1974:152), art. 2, chap. I.

⁷ 1982:763, sect. 2.

⁸ Sects. 3 and 4.

21. Many other laws in Sweden have relevance to the realization of the right to health. To take just one example, the Prohibition of Discrimination Act (SFS 2003:307) states that discrimination due to ethnic origin, religion or other beliefs is forbidden in connection with health and medical care.

B. Public health policy in Sweden

22. The main goal of Sweden's public health policy is to achieve good social conditions with a view to ensuring good health on equal terms for the entire population. The Public Health Objectives Bill⁹ sets out 11 objectives for good public health, including: economic and social security; a better health and working life; healthy, safe environments and products; healthy eating; reduced tobacco consumption; secure and safe sexuality and reproductive health; and effective prevention of the spread of diseases. These objectives are among the key determinants of the right to the highest attainable standard of health. During his mission, the Special Rapporteur was informed on several occasions that the Government did not devote adequate resources to public health policies and programmes. **The Special Rapporteur welcomes the Government's enhanced commitment to the realization of the determinants of the right to health, and encourages it to devote more resources for the achievement of these vital objectives.**

C. The need to strengthen understanding of the right to health at the national level

23. During his mission, it became apparent to the Special Rapporteur that, at the domestic level, there is a weak understanding of the right to the highest attainable standard of health. Indeed, even the existence of the right to health appeared to be unknown in some quarters where the Special Rapporteur might reasonably have expected otherwise. For the most part, explicit reference to the right to health remains absent from Sweden's domestic health policies. The Special Rapporteur was not referred to a single legal case that relied upon the right to health. All of this is surprising because, as already observed, Sweden has chosen to ratify a range of international treaties that impose upon all relevant State bodies responsibilities in relation to the right to health. While Swedish civil society organizations are doing invaluable work on health, the right to health rarely enjoys a prominent place in their activities, with a few notable exceptions.

24. What makes this unfamiliarity with the right to health at the national level especially puzzling is that Sweden has a commendable policy of actively mainstreaming human rights, including the right to health, into its international policies. To its credit, Sweden also encourages developing countries to integrate human rights into their national policies. Yet its explicit integration of the right to health into its own national policies appears to be at a rudimentary level. Some might be driven to the conclusion that, at the domestic level, Sweden does not practise what it preaches.

⁹ 2002/03:25.

25. Human rights-related principles, such as equity and access, exert a strong and beneficial influence on Sweden's domestic health laws and policies. This, however, makes the domestic unfamiliarity with the right to the highest attainable standard of health even more curious. The integration of the right to health into Swedish health policy would not signal a radical new policy departure. On the contrary, it would reinforce and strengthen much that is already being done. Of course, no method of analysis - whether based on equity, economics, utilitarianism, human rights or anything else - provides neat solutions to complex policy dilemmas. While a right to health approach does not offer neat solutions, it has a constructive contribution to make to health policymaking.

26. A policy that is animated by the right to health is likely to be equitable, inclusive, non-discriminatory, participatory, evidence-based, sustainable and robust. Thus, a failure to integrate, explicitly and consistently, the right to health, and other human rights, into Swedish health policymaking, represents a missed opportunity of significant dimensions, as well as being inconsistent with Sweden's international obligations. **Accordingly, the Special Rapporteur strongly recommends that the Government take measures to integrate the right to health, and other human rights, into all domestic health-related policymaking processes.**¹⁰

1. A national human rights plan of action

27. The World Conference on Human Rights (1993) recommended that States draw up national human rights action plans with a view to identifying how to better promote and protect human rights. Properly resourced, such plans can serve many useful purposes. Not least, they can promote the integration of human rights, including the right to health, in all relevant policymaking processes.

28. In 2002, Sweden adopted its first national human rights action plan (2002-2004).¹¹ The purposes of the plan included promoting coordination on, and raising awareness about, human rights. Regrettably, this first plan included neither a focus on the right to health, nor other economic, social and cultural rights.

29. In March 2006 a new national human rights action plan (2006-2009) was presented to the Riksdag.¹² This second plan represents a very considerable improvement on its predecessor as it includes a chapter on economic, social and cultural rights, as well as a section on the right to the highest attainable standard of health. The right to health section has a welcome focus on

¹⁰ For the Special Rapporteur's comment on Sweden's policy coherence and human rights mainstreaming at the international level, see paras. 92-115. He has also addressed these issues in several of his reports, e.g. the report of the Special Rapporteur on his mission to the World Trade Organization (2004) (E/CN.4/2004/49/Add.1), especially from paragraph 9.

¹¹ See Skr. 2001/02:83.

¹² 2005/06:95.

discrimination, inequalities and health. The plan proposes governmental measures, in the health context, to combat discrimination based on gender, ethnicity, religion or other belief, sexual orientation, and disability.¹³

30. The Special Rapporteur recommends that Sweden's second national human rights action plan lead to human rights training, including on the right to health, for staff at the Ministry of Health and Social Welfare, as well as other national, county and municipal bodies dealing with health-related matters.¹⁴ Such training is a precondition for the mainstreaming of human rights, including the right to health, in all relevant policymaking processes. If the plan is to be effective, it is imperative that it enjoy high-level political leadership and be adequately staffed and resourced.

2. A national human rights institution

31. Sweden is rightly famous for, and proud of, the ombudsman institution. It has a number of ombudsmen undertaking very important work on various aspects of human rights, including the Ombudsman on disability and the Ombudsman against ethnic discrimination. Although these institutions are carrying out indispensable work, their responsibilities do not extend to all aspects of all human rights. The right to the highest attainable standard of health, for example, is not fully encompassed within their various mandates.

32. Many States, including some in Scandinavia, have already established national human rights institutions that promote and protect the whole spectrum of civil, political, economic, social and cultural rights, and not only those human rights elements presently covered by Sweden's ombudsmen.

33. Properly resourced, a Swedish national human rights institution could deepen the domestic understanding of the right to health among policymakers, the judiciary, health professionals, civil society and the population at large. Like Sweden's second human rights action plan, a national human rights institution could help to mainstream human rights, including the right to health, in all relevant policymaking processes. Given appropriate powers, it could also provide a way of enhancing the accountability of the State, and others, in relation to their right to health responsibilities. **The Special Rapporteur strongly recommends that steps be taken urgently to establish a Swedish national human rights institution, consistent with the Paris Principles (1991), in a manner that does not jeopardize the vital work of Sweden's existing ombudsmen. Such an initiative will help to ensure that Sweden remains abreast of contemporary developments in the field of national and international human rights.**

¹³ Åtgärd 55, p. 67.

¹⁴ In 2001, the Committee on Economic, Social and Cultural Rights also encouraged Sweden "to raise awareness about human rights, in particular economic, social and cultural rights, among State officials and the judiciary" (E/C.12/1/Add.70; para. 35).

IV. THE REALIZATION OF THE RIGHT TO HEALTH AT THE NATIONAL LEVEL: SOME ISSUES OF PARTICULAR CONCERN

A. Is appropriate health care accessible to all?

34. The right to health includes an entitlement to health-care goods, services and facilities which are available in adequate supply within a State; accessible geographically, financially and on the basis of non-discrimination; culturally acceptable, including to minorities, indigenous populations and women; and of good quality.¹⁵

35. To the credit of the Government, health care is generally available and of a high quality in Sweden. Even so, particular services related to health, such as harm-reduction programmes, are not available in adequate numbers across the jurisdiction (see paragraphs 60-62).

36. A high-cost protection scheme means that patients pay a maximum of SKr 900 over a 12-month period for outpatient care. However, costs have adversely affected the financial accessibility of health care for some population groups. Under the Dental Care Act (1999), for example, patients bear some of the costs for many dental procedures. The cost of dental care has risen significantly since 1999. Although there are exemptions for children and youth up to 19 years of age and for persons over 65 years of age, and despite the maximum payment of SKr 900 over a one-year period, the Special Rapporteur was informed that fees have adversely affected the take-up of dental services, especially for people living in poverty.

37. In contrast to Swedish residents and citizens, undocumented foreign nationals have to pay full fees for health care, including for emergency procedures (see paragraphs 67-75). The costs of such services are unaffordable for many undocumented foreign nationals.

38. In addition to problems of financial accessibility, some services are inaccessible to vulnerable populations for other reasons. For example, the Special Rapporteur was informed that homeless persons have difficulty in accessing mental health-care services because they lack a permanent address.

39. In terms of acceptability, the Special Rapporteur was concerned that health care was not entirely sensitive to the culture of some groups, such as the Sami (see paragraphs 51-59).

40. Under ICESCR and other treaties, it is incumbent on the Government to guarantee the availability, accessibility, acceptability and quality of health-care facilities, goods and services. The Special Rapporteur commends the Government on its overall performance. However, he is concerned at the problems that a range of marginalized communities face in accessing health-care services on account of discrimination, costs of services, or because services do not respond adequately to cultural considerations. These inequities are prima facie incompatible

¹⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12.

with fundamental right to health principles, including equality and non-discrimination. They would also appear to be inconsistent with the guiding objective of the Swedish Health and Medical Services Act to guarantee the entire population good health on equal terms.

41. The Ombudsmen on disability, ethnic discrimination and sexual orientation are currently undertaking a study on the impact of discrimination on health. The Swedish National Institute of Public Health (SNIPH: Folkhälsoinstitut) is also charged with undertaking surveys on discrimination and health. Sweden's national human rights action plan (2006-2009) proposes governmental measures to combat discrimination on grounds of gender, ethnicity, religion or other belief, sexual orientation and disability, and its impact on access to, and quality of, health care. **The Special Rapporteur welcomes these studies, surveys and proposals. He recommends that the Government take measures to combat inequalities in health status and access to care. These measures should focus not only on discrimination, but also on other closely-related obstacles, such as the costs of care which render health care inaccessible for some population groups.**

B. Mental health

42. Mental health is deteriorating in Sweden.¹⁶ Sleeping disorders, depression, anxiety and other types of nervous problems are increasing, and sales of anti-depressant drugs increased fivefold between 1992 and 2003.¹⁷

43. The Special Rapporteur was informed of a range of problems regarding access to, and coordination within, mental health care and related support services. Unless the situation is urgent, waiting times for mental health care are lengthy. The number of psychiatric hospital beds decreased from 14,533 in 1990 to 4,606 in 2003:¹⁸ the current number of beds is reportedly not commensurate with need. There is also inadequate coordination between services provided by counties (e.g. psychiatric services, which are integrated within the health-care system) and related services provided by municipalities (e.g. counselling and support services to persons with psychosocial disabilities, persons in sheltered accommodation and support for the elderly). Crucially, in the last decade there has been a decrease in the percentage of the overall health budget spent on mental health care.¹⁹

44. There is a high incidence of psychosocial disabilities among specific population groups, including homeless persons.²⁰ Up to a quarter of refugees and asylum-seekers are affected by

¹⁶ *2005 Public Health Policy Report*, SNIPH.

¹⁷ National Board of Health and Welfare, *Folkhälsorapport 2005*, p. 143.

¹⁸ See Glengard et al., *op. cit.*

¹⁹ *Utveckling av stöd och vård åt psykiskt störda lagöverträdare* (SOU 2006:2), p. 168.

²⁰ *Så Vill vi Had Den, Patient-, brukar- och anhörignätverkets krav på framtida vård, stöd och behandling inom psykiatriområdet*, 2006.

post-traumatic stress disorder.²¹ Refugees, asylum-seekers and homeless persons all reportedly have difficulty accessing mental health care. Among children and young people, suicide, bulimia and anorexia are increasing. However, there are few mental health programmes focused on children and young persons. Discrimination and stigma have reportedly created a high incidence of psychosocial disabilities among lesbian, gay, bisexual and transgender persons. The Special Rapporteur was informed that psychosocial disabilities are the leading cause of ill-health among women in Sweden: violence and discrimination against women have contributed to this situation.

45. Recently, the Government has commendably made mental health policies and programmes a higher priority. In 1995, the Government adopted a mental health reform which had the objective of improving the quality of life of users of mental health care. The Public Health Objectives Bill²² sets out several objectives connected to preventing psychosocial disabilities, including creating a healthier working life, and secure and favourable conditions during childhood. The Special Rapporteur welcomes these commitments.

46. Following the murder in 2003 of the then Minister for Foreign Affairs, Anna Lindh, by a man with a psychosocial disability, the Government appointed a National Coordinator for Psychiatry, with the objective of improving the quality of care for people with psychosocial disabilities. In 2006, the Coordinator released recommendations for two new laws to complement the Compulsory and Forensic Mental Care Acts.²³ The proposals include a provision whereby, instead of the contemporary law and practice of providing compulsory care in institutions, some individuals who have serious disabilities should be able to live in the community, providing they are subject to, and comply with, compulsory treatment orders. While the Special Rapporteur supports the proposed extension of community-based care, he is concerned that the proposals do not give adequate weight to the participation of persons with psychosocial disabilities in decisions about their treatment and medication. Participation in decisions about treatment is an important feature of the right to health.

47. The Special Rapporteur urges the Government to ensure the full realization of the rights of persons with psychosocial disabilities, as expressed in international and regional human rights treaties, and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities.

48. The Special Rapporteur welcomes the focus in the Public Health Objectives Bill on addressing the causes of psychosocial disabilities among the population, and urges the Government to ensure adequate funding for these measures. The Special Rapporteur urges the Government to ensure that it takes measures to address causes of psychosocial

²¹ National Institute for Psychosocial Medicine, *Migration and Stress*, June 2004.

²² 2002/03:25.

²³ 1991:1128 and 1991:1129.

disabilities among vulnerable and marginalized groups, including children,²⁴ adolescents, homeless persons, women, asylum-seekers, and lesbian, gay, bisexual and transgender persons.

49. He urges the Government to ensure that mental health care, including psychiatric care and other therapies, is made more accessible for marginalized groups. He also suggests that central Government, counties and municipalities should devote more attention to ensuring coordination between services, and the provision of more services and programmes for children and adolescents.

50. The Special Rapporteur supports the provision of mental health care in deinstitutionalized, community-based settings. However, he recommends that the Government also ensure that the number of available psychiatric hospital beds is sustained at a level commensurate with need.

C. The Sami

51. The Sami, the indigenous people of northern Scandinavia, live in the polar region extending from Norway, Sweden and Finland to the Kola Peninsula in the Russian Federation. The population is estimated at 70,000-100,000, of which 17,000-20,000 live in Sweden.²⁵ About 15 per cent of Swedish Sami are involved in the traditional economy, which includes reindeer herding and fishing.

52. Like the Swedish population as a whole, the Sami tend to enjoy a standard of living, life expectancy and health status that are among the best in the world. However, they face notable health problems, some of which are common to the entire Swedish population and some of which are distinctive: psychosocial disabilities, alcohol and substance abuse, violence, and occupational injuries arising from reindeer herding.

53. As the indigenous people of Sweden, the Sami enjoy a special status in both national and international human rights law. To its credit, Sweden has taken a number of steps to turn this special status into meaningful measures. In 1977, the Swedish Parliament recognized the indigenous status of the Sami. In 1993, the Government established the Sami Parliament. In 2000, the Sami Language Act gave the Sami the right to use their own language in legal and administrative proceedings. The Special Rapporteur commends the Government for adopting these important measures that are reflective of the Sami's special status.

²⁴ In 2005, the Committee on the Rights of the Child recommended that the Government of Sweden should "strengthen mental health programmes for children, both preventative and interventional" (CRC/C/15/Add.248, para. 32 (e)). The Special Rapporteur endorses this recommendation.

²⁵ *The Sami, an Indigenous People in Sweden*, Sami Parliament and Ministry of Agriculture, Food and Consumer Affairs, 2005.

54. In this context, the Special Rapporteur is especially interested in two questions. One, has the Government carefully and systematically considered the Sami's special status in the context of health? Two, if so, has this consideration translated into the identification and implementation of meaningful, practical measures relating to health? Here, the focus is on the second of these questions.

55. Given the special status of the Sami, the Special Rapporteur was surprised to find that Sweden does not have a Sami health research centre. This omission tends to explain what he was told by some while on mission: there is a shortage of research and knowledge focusing on the health of the Swedish Sami. As it was put in 2004: "Over the last decades, only a few studies have been published addressing health and disease in the Swedish Sami population."²⁶

Accordingly, the Special Rapporteur recommends that the Government support the establishment of a Sami health research centre, along the lines of the Centre for Sami Health Research based at the University of Tromsø, Norway.

56. During his mission, the Special Rapporteur was also informed that there are no operational units - at the national, county or municipal levels of government - focusing on the promotion of Sami health. For example, he was advised that no county councils, not even in Norrbotten, which has the highest density (nearly 50 per cent of the Sami population in the country), have a discrete unit to ensure that Sami health issues are given the attention they deserve. **Given the special status of the Sami, he also finds this omission surprising, and he recommends that it be subject to urgent review. For example, presently the Ministry of Agriculture has executive responsibility for all issues relating to the Sami. The Special Rapporteur suggests that the Government consider establishing a body within the Ministry of Health with national responsibility for oversight of Sami health.**

57. The Special Rapporteur was pleased to hear that the Sami Parliament has held discussions on a Sami dimension to Swedish health policy. However, he was surprised to learn that Sweden lacks a national health policy for the Sami. Also, Sweden lacks an occupational health policy designed for the distinctive health hazards of reindeer herders. Moreover, he was informed that some Sami reindeer herders have sometimes met with a lack of understanding in health-care facilities in relation to their occupational injuries. Whether or not such complaints are systemic or exceptional, Sweden is vulnerable to criticism in the absence of an occupational health policy catering for the particular hazards of reindeer herders. Further, the Sami language is not used in the health-care context. Of course, it would be absurd to suggest that all health services throughout Sweden should be available in Sami. Nobody is making such a suggestion. However, Sami representatives informed the Special Rapporteur that they wish, so far as practical, to develop capacity for the delivery of health care and health information in the Sami language. Such an aspiration would appear to be entirely reasonable, as well as consistent with the special status of the Sami.

²⁶ S. Hassler, P. Sjölander and A. Ericsson, *Construction of a database on health and living conditions of the Swedish Sami population*, Centre for Sami Research, Umeå University, 2004, p. 107.

58. **If the Sami Parliament confirms that it would welcome a Sami national health policy, the Special Rapporteur urges the development and adoption of such an evidence-based policy, by way of an inclusive, participatory process that is respectful of Sami custom and practice.²⁷ Serious consideration should also be given to the adoption of an occupational health policy designed to respond to the distinctive hazards confronting reindeer herders. The Government should develop an action plan to enhance capacity for the delivery of health care and information in the Sami language. Health professionals should be provided with training in Sami culture.**

59. **The Special Rapporteur now returns to the second question posed in paragraph 54. He regrets that he found little, if any, evidence that Sweden has translated the special status of the Sami into meaningful, practical measures in the health context.**

D. Needle exchange for intravenous drug users: the need for an integrated, comprehensive harm-reduction policy

60. During his mission, the Special Rapporteur had the opportunity to visit Malmö, where he met with individuals involved in an important harm-reduction programme for intravenous drug users. This project provides intravenous drug users with comprehensive and integrated treatment and counselling, and with clean needles and syringes. A midwife engaged in the project also dispenses contraception and offers contraceptive advice and pregnancy counselling, including with respect to prevention of vertical transmission of hepatitis and HIV. Not only has this project proven to be highly effective in terms of public health objectives (i.e. it prevents the spread of disease), but it also enhances the realization of the right to health, including sexual and reproductive health, for intravenous drug users.

61. These results are in line with the worldwide experience that harm-reduction programmes, including needle exchange programmes and associated health care, promote and protect the health of drug users and reduce transmission of communicable diseases such as hepatitis B and C and HIV, including vertical transmission to newborn children from pregnant intravenous drug users or their partners. These programmes are highly cost-effective.²⁸

62. Harm-reduction programmes are endorsed by the World Health Organization,²⁹ the United Nations Office on Drugs and Crime and the Joint United Nations Programme on HIV/AIDS. The Special Rapporteur was very surprised to learn that the Malmö project is one of only a very small number of its kind in Sweden. He is encouraged that, in 2006, a reform was adopted allowing health and social services across the country to introduce needle exchange

²⁷ For some of the relevant Norwegian Sami experience, see Arctic Development Report 2004, Stefannson Arctic Institute, 2004.

²⁸ See, for example, R. Elliott et al., "Harm reduction, HIV/AIDS, and the global rights challenge to global drug control policy", *Health and Human Rights: An International Journal*, vol. 8, No. 2, 2005.

²⁹ See www.who.int/hiv/topics/harm/reduction/en/.

programmes coupled with treatment and counselling programmes. However, such an important human rights issue cannot be left to the discretion of local government. **The Special Rapporteur emphasizes that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm-reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes.**

E. Human rights education for health professionals

63. Health professionals are often witness to the effects of torture and violence, substandard living and work environments, and gender-, ethnicity- and disability-based discrimination. They can play a key role in monitoring, documenting and achieving redress for human rights abuses.

64. The practice of health professionals has a bearing on the various aspects of the right to health, including medical confidentiality, privacy and equitable access to treatment. During his mission, the Special Rapporteur was concerned about reports that health professionals in Sweden did not always know about, and sometimes acted contrary to, their patients' human rights.

65. In addition to clinical responsibilities, health professionals have a duty to promote and protect the right to health, as well as other human rights.³⁰ Knowledge of human rights is integral to their ability to perform this role. The World Medical Association has recommended that medical schools integrate ethics and human rights as an obligatory course in curricula.³¹

66. Regrettably, human rights training has not traditionally been part of the obligatory curricula for health professionals in Sweden. However, in 2006, the Government introduced amendments to the Higher Education Ordinance (1993:100), requiring students enrolled in the majority of professional degree courses to be able to make judgements, and have a professional approach, that takes account of human rights. **The Special Rapporteur welcomes this development. He encourages the Government, and other bodies regulating medical and nursing school curricula, to introduce in practice human rights education - including on economic, social and cultural rights - into health professional curricula.³² He also recommends that the Government ensures that health professionals who have already qualified are offered adequate opportunities to undergo human rights training.³³**

³⁰ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 42.

³¹ Declaration of Tokyo, WMA, 1999.

³² Also see Sweden's national human rights plan of action, 2001, chap. 9.

³³ For more information on human rights training for health professionals, see the report of the Special Rapporteur to the General Assembly (A/60/348).

F. Asylum-seekers and undocumented foreign nationals

67. Sweden has an honourable tradition of receiving asylum-seekers and other categories of foreign nationals. In 2004 there were approximately 20,000 asylum-seekers in Sweden.³⁴

68. Applications for asylum are examined by the Swedish Migration Board. Recently, the duration of the asylum process was on average 18 months, but in some cases it was longer. Until this year, appeals against decisions taken by the Swedish Migration Board were made to the Aliens Appeal Board, an administrative agency and a final-decision-making body. In order to improve the asylum process and reduce delays, the Government established a new procedure and system in March 2006. The Special Rapporteur welcomes this development.³⁵

69. Asylum-seeking children have access to the same health care on the same basis as children domiciled in Sweden. However, asylum-seeking adults do not have access to the same health care as adults domiciled in Sweden. In the Special Rapporteur's opinion, such differential treatment constitutes discrimination under international human rights law.

70. The very difficult situation of undocumented people living in Sweden (*gömnda*) has been brought to the attention of the Special Rapporteur. They represent one of the most vulnerable groups in society, consisting predominantly of rejected asylum-seekers, as well as immigrants who have never claimed asylum but overstayed in Sweden. There are an estimated 15,000 undocumented people living in Sweden.

71. Undocumented children receive health care on the same basis as resident children. Undocumented adults may receive immediate health care, but at their own expense. Undocumented people who seek medical care in a public health-care facility will receive the treatment required.³⁶ However, they will have to pay the full cost of the treatment and medication.³⁷ A further problem is that undocumented people fear being reported to authorities by medical staff and thus they often refrain from seeking medical assistance even in the most serious cases.³⁸

³⁴ Migrationsverket, *Facts and Figures*, 2004.

³⁵ The Special Rapporteur was informed that lengthy asylum processes can have negative effects on the health of asylum-seekers. From the point of view of the right to health, reducing the length of the processes is an important step.

³⁶ Under Swedish law, no health institution can turn away a person in need of immediate care, regardless of his or her legal status, financial situation, etc.

³⁷ A consultation with a doctor at a primary health-care clinic is SKr 140 for Swedish nationals and SKr 1,400 for *gömnda*. See Médecins Sans Frontières, *Experiences of Gömda in Sweden*, 2005.

³⁸ Ibid. The Special Rapporteur notes that under the Secrecy Act (1980:100), general care staff are, as a general rule, prohibited from divulging information of individuals.

72. The Special Rapporteur is concerned that Swedish law and practice regarding the health care accessible to asylum-seekers and undocumented foreign nationals is not consistent with international human rights law. In 2000, the Committee on Economic, Social and Cultural Rights, which monitors and interprets ICESCR, advised: “States are under an obligation to respect the right to health by refraining from denying or limiting equal access for all persons, including ... asylum-seekers and illegal immigrants, to preventive, curative and palliative health services.”³⁹ In 2004, another United Nations committee of independent human rights experts took the same position.⁴⁰ The Special Rapporteur sees no reason to take a different view. The Special Rapporteur notes that under international human rights law, some rights, notably the right to participate in elections, to vote and to stand for election, may be confined to citizens. However, human rights are, in principle, to be enjoyed by all persons.⁴¹

73. A fundamental human right, the right to the highest attainable standard of health is to be enjoyed by all without discrimination. It is especially important for vulnerable individuals and groups. Asylum-seekers and undocumented people are among the most vulnerable in Sweden. They are precisely the sort of disadvantaged group that international human rights law is designed to protect.

74. As well as human rights and humanitarian reasons, there are also compelling public health grounds for treating all asylum-seekers and undocumented people on the same basis as Swedish residents. While on mission, it was not suggested to the Special Rapporteur that the estimated cost of extending the same medical services on the same basis to residents, asylum-seekers and undocumented individuals would be prohibitively expensive. The issue does not appear to be primarily one of cost. Indeed, relatively speaking, the costs of including asylum-seekers and undocumented individuals are unlikely to be significant.

75. Accordingly, the Special Rapporteur encourages the Government to reconsider its position with a view to offering all asylum-seekers and undocumented persons the same health care, on the same basis, as Swedish residents. By doing so, Sweden will bring itself into conformity with its international human rights obligations.

Asylum-seeking children with severe withdrawal behaviour

76. The Special Rapporteur notes with particular concern the high incidence of severe withdrawal behaviour among asylum-seeking children in Sweden (the so-called “apathetic children”). These children appear to have become severely withdrawn, with some refusing to eat

³⁹ Committee on Economic, Social and Cultural Rights, *op. cit.*, para. 34.

⁴⁰ Committee on the Elimination of Racial Discrimination, general recommendation No. 30 (2005), para. 36. The Special Rapporteur notes that the protections of international human rights law are more extensive in their scope than Council Directive 2003/9/EC (27 January 2003).

⁴¹ For example, *ibid.*, para. 3.

and/or communicate. The most difficult and severe cases present symptoms akin to a psychological condition known as Pervasive Refusal Syndrome: those affected often require tube-feeding to stay alive.

77. Acknowledging the need to address the problem, in 2004 the Government appointed a National Coordinator for children with severe withdrawal behaviour in the asylum process. The National Coordinator was tasked with providing an overview and analysing the incidence of this problem, which mostly affects children of rejected asylum-seekers. According to the results of the National Coordinator's survey, Sweden has the largest number of registered cases (424 children). In 2006, the National Coordinator published another report on the situation of children with severe withdrawal behaviour.⁴² The Special Rapporteur commends the Government for its commitment to investigating the nature and scale of the problem.

78. During the mission, the Special Rapporteur had the opportunity to discuss severe withdrawal behaviour with clinical psychologists, sociologists, representatives of NGOs and the National Coordinator. He visited a child suffering from severe withdrawal behaviour, and had the opportunity to discuss his situation with his father, the treating psychiatrist, a nurse and the head of the paediatrics department.

79. Severe withdrawal behaviour is a complex medical issue. To date, there appears to be inadequate medical research on this condition. This has given rise to varying - and sometimes conflicting - medical opinions about causes and treatment.

80. Some experts argue that the anxiety of traumatized children arising from the uncertain outcome of their asylum application may be a cause, and call for granting asylum to these sick children. Other experts, including the National Coordinator, emphasize the high incidence of the syndrome in Sweden in comparison with other countries, and that the behaviour primarily occurs among children of certain ethnic backgrounds, suggesting that psychosocial mechanisms fuel the syndrome. Others have highlighted the existence of similar syndromes in other countries (Finland, Norway and Austria), albeit on a much smaller scale,⁴³ and the existence of pervasive withdrawal syndrome beyond Sweden.⁴⁴ The health professionals with whom the Special Rapporteur met stated categorically that there was no possibility that children with acute symptoms of severe withdrawal behaviour could be faking.

81. While the Special Rapporteur, for a number of compelling reasons, is unable to make assessments of a clinical nature about these children, he wishes to emphasize the following remarks.

⁴² *Asylum-seeking children with Severe Withdrawal Behaviour: Trauma, Culture and the Asylum Process*, Report of the National Coordinator, 2006.

⁴³ *Asylum-seeking children with Severe Withdrawal Behaviour: Status of knowledge and Survey*, Report of the National Coordinator, 2005.

⁴⁴ B. Lask, "Pervasive Withdrawal Syndrome", *Advances In Psychiatric Treatment*, vol. 10 (March 2004), pp. 153-159.

82. **First, while the debates about the condition partly reflect the inadequate medical understanding of the problem, the Special Rapporteur is concerned that these debates may sometimes have been caught up in highly politicized public discussion about asylum and immigration in Sweden. Crucially, the plight of these children must be understood as a health and human rights issue, not as a political or immigration issue.**

83. **Second, the right to health demands evidence-based health policies and interventions. The Special Rapporteur recommends that the Government actively and urgently support more research into the medical, environmental and psychosocial causes of severe withdrawal behaviour, as well as its most appropriate medical treatment.**

84. **Third, the Special Rapporteur is aware that human rights have not been absent from discussions about children with severe withdrawal behaviour. Nonetheless, in his view the human rights dimensions of the issue should receive more attention. In addition to the necessity of greater medical research, he wishes to emphasize that all relevant policies and interventions must be guided by human rights. In particular, all parties concerned should ensure that the best interests of the child,⁴⁵ and the right of the child to the highest attainable standard of health, “including to necessary medical assistance and health care”,⁴⁶ guide policies and interventions, without discrimination.**

85. **Fourth, as a way of ensuring that the human rights dimensions of the problem receive more systematic and considered attention than hitherto, the Special Rapporteur recommends that the Ombudsman on children be given the formal and important role of closely monitoring this problem in general, as well as individual cases, from the perspective of the rights of the child. The Ombudsman should make recommendations and report publicly, regularly and officially on her findings.**

G. Expulsion of foreign nationals with life-threatening conditions

86. As is the case in other European countries, health problems generally do not entitle a foreign national to a residence permit in Sweden. Sweden’s revised Aliens Act, which entered into force in March 2006, recognizes that health considerations amounting to “particularly distressing circumstances” may constitute grounds for a residence permit.⁴⁷

87. The term “particularly distressing circumstances” replaces the term “humanitarian grounds” included in the old Aliens Act.⁴⁸ Under the old Aliens Act, it was recognized that life-threatening illness for which no treatment could be provided in an alien’s home country could sometimes constitute “humanitarian grounds for a residence permit”.

⁴⁵ Convention on the Rights of the Child, art. 3.

⁴⁶ Ibid., art. 24.

⁴⁷ 2005:716.

⁴⁸ 1989:529.

88. While welcoming inclusion of health considerations in the legislation, the Special Rapporteur is concerned that decisions under the old Aliens Act only took into account the availability of a required treatment in the applicant's home country, but not the accessibility of the treatment to the particular individual in question.⁴⁹

89. The European Court of Human Rights has made several decisions about whether the deportation of an alien with a life-threatening illness would constitute inhuman or degrading treatment⁵⁰ in the event that treatment was unavailable in the country of destination. The Court has found a violation only in the most exceptional of circumstances, such as imminent death or severe physical and mental suffering.⁵¹ In 2000, the Court gave an admissibility decision in *S.C.C. v. Sweden*, a case involving the potential return to Zambia of a woman living with HIV. The Court found the case inadmissible. The Court declined to take into consideration the applicant's claim that she did not have the financial means to access in Zambia the drugs that she needed to maintain her health and prolong her life.⁵²

90. While the facts in the *S.C.C.* case may not have reached the threshold to be considered a violation of the prohibition against inhuman and degrading treatment, the Special Rapporteur has no doubt that they have major right to health implications. Returning an individual with a life-threatening condition to a country where life-saving treatment is inaccessible to the individual in question is prima facie inconsistent with the individual's right to the highest attainable standard of health. **The Special Rapporteur recommends that in their assessment of "particularly distressing circumstances" under the new Aliens Act, migration courts consider whether or not the individual, in practice, would be able to access life-saving treatment.**

91. In cases under the Aliens Act, the Swedish Embassy in the country in question is often requested to provide an assessment of whether an alien may be able to receive treatment in his or her home country. These reports are one of several sources available to the Swedish migration authorities for assessing the situation in a particular country. The Special Rapporteur was concerned at reports that the Embassy assessments drew on limited sources, were of poor quality, and limited to the question of availability. **He recommends that efforts be made to improve the quality of, and integrate considerations about the accessibility of drugs into, these assessments. After all, how helpful is an assessment that finds a treatment is available in the home country, when it is well known that the treatment lies beyond the reach of all but the country's rich elite?**

⁴⁹ European Court of Human Rights, *S.C.C. v. Sweden*, admissibility decision, 15 February 2000.

⁵⁰ European Convention on Human Rights, art. 3.

⁵¹ See, for example, *D. v. United Kingdom*, decision of 2 May 1997.

⁵² European Court of Human Rights, *op. cit.*

V. SWEDEN'S FOREIGN POLICY: REALIZING THE RIGHT TO HEALTH AT THE INTERNATIONAL LEVEL

A. Integration of the right to health into Sweden's foreign policies

92. The Special Rapporteur's work is guided by the fundamental principle that national and international human rights law, including the right to the highest standard of health, should be consistently and coherently applied across all relevant national and international policymaking processes.⁵³ This fundamental principle is reflected in Sweden's foreign policy. In *Human Rights in Swedish Foreign Policy*, the Government pledges to integrate human rights into all areas of foreign policy and to mainstream human rights into the work of global and regional organizations.⁵⁴ The realization of the right to health in developing countries is affected not just by their own Governments' actions, but also by rich countries' international policies relating to aid, finance, trade, the environment and security, as well as the actions of international organizations. Therefore, the Special Rapporteur warmly endorses the commitment of the Swedish Government to integrate human rights, including the right to health, across all its foreign affairs.

93. The Government's commendable policy, however, gives rise to two major questions. First, to what degree has this policy actually been brought to bear upon all aspects of Sweden's foreign policy? For example, while the policy has been given careful consideration by Sida, has it also been given due attention in relation to Sweden's policies regarding the World Bank, International Monetary Fund (IMF) and international trade? Second, to what degree has the policy actually been operationalized? Has Sida, for example, managed to operationalize the policy on the ground in developing countries?

94. While on mission, the Special Rapporteur asked these challenging questions and he is very grateful to all those in Government and beyond who answered them in an open and frank manner. It soon became clear, however, that if these questions are to be subject to close examination, they should not only be put to public officials in Stockholm, but also to some of those working overseas.

95. Thus, the Special Rapporteur is very pleased that the Government agreed that he may pursue these important matters by meeting with those executive directors who represent Sweden's interests in the World Bank and IMF. The Government has also agreed that the Special Rapporteur may visit the Swedish Embassies, including relevant projects, in one or two developing countries where Sida is supporting health-related activities. In early 2007, the Special Rapporteur will visit Uganda with a view to considering Sida's integration of the right to

⁵³ See paras. 25-35 on integration of human rights in Sweden's domestic policies.

⁵⁴ *Human Rights in Swedish Foreign Policy*, Government Communications 1997/98:89 and 2003/04:20.

health into its activities in this country, obstacles encountered and good practices.⁵⁵ The Special Rapporteur is very grateful to the Governments of Sweden and Uganda for acceding to his request.

96. In these circumstances, the present report only serves as a brief introduction to these issues because it is anticipated that some of them will be examined in more detail in a subsequent report.⁵⁶

1. International development policies and Sida

97. Sweden's policies and programmes in relation to international development, poverty reduction, health and human rights are among the best in the world. In general, they make a very positive contribution towards the realization of the right to health in developing countries. They deserve applause, support and study.

98. In 2002, in *Shared Responsibility: Sweden's Policy for Global Development*, the Government confirmed that the human rights perspective would be mainstreamed across all areas of policy related to international development.⁵⁷ Subsequently, human rights have been integrated into many of Sweden's international development and health-related policies.

99. For example, human rights are one of four key strategies guiding Sweden's international health and development policy.⁵⁸ In 2006, the Government adopted its *International Policy on Sexual and Reproductive Health and Rights*, an important and pioneering policy that will contribute to a more rational and human rights-based approach to these extremely important issues. To its credit, Sida has drawn up a guide for country-level analysis from the human rights perspective.⁵⁹

100. The Special Rapporteur looks forward to considering how these, and other relevant policies and guides, have been operationalized when he undertakes his follow-up to the mission of January 2006.⁶⁰ In the meantime, he makes the following preliminary remarks.

⁵⁵ The subsequent report on this visit will not focus on the policies and practices of Uganda, save to the extent that they bear upon Sida's work.

⁵⁶ It is anticipated that the Special Rapporteur will prepare, and submit to the Human Rights Council, an additional report on his visits to Washington DC and the relevant developing country or countries.

⁵⁷ Government Bill 2002/03:122.

⁵⁸ *Health is Wealth: Policy for Health and Development*, Sida, 2002.

⁵⁹ *Country Strategy Development: Guide for Country Analysis from a Democratic Governance and Human Rights Perspective*, Sida, 2001.

⁶⁰ See para. 98 above.

101. The Special Rapporteur congratulates the Government of Sweden for surpassing the commitment by developed States to devote 0.7 per cent of GNP to official development assistance (ODA), and for moving towards committing 1 per cent of GDP to ODA by 2006. This level of aid can play a vital role in helping to operationalize the right to health. Of course, aid quality remains a vital consideration.

102. Within the governmental administration, the Department for Global Development has a particular responsibility to promote the mainstreaming of human rights across Sweden's international development activities, in line with Shared Responsibility: Sweden's Policy for Global Development. At the time of his visit to Sweden, while 12 staff were assigned to this Department, only 5 were actually appointed and in post. **The Special Rapporteur strongly recommends that the Department's staffing capacity be significantly increased as a matter of urgency.**

2. World Health Organization

103. The right to the highest attainable standard of health is recognized in the Constitution of the World Health Organization (WHO). In its eleventh General Programme of Work (2006-2015), WHO recognizes that health-related human rights are a core value and principle guiding its work.

104. Sweden is a member of the World Health Assembly, the Organization's supreme decision-making body. Sweden also provides support to WHO through its voluntary contributions to the Organization. In addition to core (i.e. unearmarked) support, Sweden provides important thematic support for WHO on some important right to health issues, notably sexual and reproductive health and rights.

105. Sweden is also currently supporting the employment of an Associate Professional Officer as a Health and Human Rights Officer in the WHO country office in Uganda. The Special Rapporteur commends this initiative and notes the excellent collaboration he had with the WHO office in Uganda when he undertook a formal mission to this country in 2005.⁶¹

106. **The Special Rapporteur commends the Government of Sweden for its general support of WHO. He urges the Government to ensure that its contributions to WHO continue to support sexual and reproductive health and rights. However, he also urges the Government to broaden and deepen its support to other vital areas of the Organization's work. The Special Rapporteur encourages Sweden to further support the mainstreaming of human rights throughout WHO, such as by supporting the development and adoption of a WHO strategy/policy on human rights in relation to its mandate.**

⁶¹ See E/CN.4/2006/48/Add.2.

World Bank and International Monetary Fund

107. The Special Rapporteur commends Sweden and other Nordic countries for setting up a World Bank trust fund, called the Justice and Human Rights Trust Fund, to promote the integration of human rights considerations into the activities of the Bank and to allow the Bank to respond positively to requests from its client States on these important issues.

108. **In 2001, the Committee on Economic, Social and Cultural Rights encouraged Sweden, as a member of international financial institutions, in particular IMF and the World Bank, to “do all it can to ensure that the policies and decisions of those organizations are in conformity with the obligations of States parties to the Covenant, in particular the obligations contained in articles 2.1, 22 and 23 concerning international assistance and cooperation”.**⁶² The Special Rapporteur endorses this recommendation.

3. World Trade Organization

109. **In line with the preceding paragraph, the Special Rapporteur recommends that, in light of Sweden’s various policies on foreign affairs, including international development, as well as its responsibilities under ICESCR and other human rights treaties, the right to health should inform Sweden’s policies and actions in relation to international trade agreements with a bearing upon health, including the Agreement on Trade-related Intellectual Property Rights.**⁶³

B. Sweden’s human rights responsibility of international assistance and cooperation

110. Throughout his mandate, the Special Rapporteur has taken the position that a rich State’s human rights responsibility to provide international assistance and cooperation is underpinned by a legal obligation. The Committee on Economic, Social and Cultural Rights, and others, adopt the same position.⁶⁴ It is accepted that the parameters and content of this legal obligation are not yet clearly defined, but the same can be said for a number of human rights. In brief, the legal obligation can be traced from the Charter of the United Nations,⁶⁵ through to the Universal Declaration of Human Rights,⁶⁶ and binding human rights treaties, such as the International

⁶² Committee on Economic, Social and Cultural Rights, concluding observations: Sweden (E/C.12/1/Add.70) (2001).

⁶³ Note that Sida’s trade policy is guided by human rights: *Sida’s Policy for Trade-related Development* (Sida, 2005).

⁶⁴ See for example Committee on Economic, Social and Cultural Rights, general comment No. 14, op. cit., paras. 38-42.

⁶⁵ E.g. Articles 1, 55 and 56.

⁶⁶ Especially articles 22 and 28.

Covenant on Economic, Social and Cultural Rights⁶⁷ and the Convention on the Rights of the Child.⁶⁸ It is also reflected in compelling world conference outcomes, such as the United Nations Millennium Declaration. This human rights responsibility of international assistance and cooperation extends to health.

111. Space does not permit here a detailed consideration of these sensitive and important issues. Accordingly, the Special Rapporteur confines himself to the following points.

112. First, the human rights responsibility of international assistance and cooperation should not be understood as only encompassing financial assistance from North to South. It also includes, for example, a procedural responsibility on rich States not to withdraw critical aid without first giving the recipient a reasonable opportunity to make alternative arrangements.⁶⁹

113. Second, if there is no legal obligation underpinning the human rights responsibility of international assistance and cooperation, inescapably all international assistance and cooperation is based fundamentally upon charity. While such a position might have been tenable 100 years ago, it is unacceptable in the twenty-first century.

114. Third, the Special Rapporteur acknowledges that Sweden, like other rich States, does not accept that it has a legal obligation of international assistance and cooperation. He wishes to emphasize, however, that since Sweden's international policies in general provide very significant support for developing States, recognition of a legal obligation underpinning its human rights responsibility of international assistance and cooperation would primarily serve to reinforce Sweden's existing international policies and practices. In short, for a country with Sweden's commendable record, recognition of a legal obligation would not in practice mark a significant departure. **Accordingly, the Special Rapporteur encourages Sweden to play a leading role in exploring the contours, content and legal nature of the human rights responsibility of international assistance and cooperation.**

115. **He also recommends that the Government routinely include, in its State party reports to relevant human rights treaty bodies, information on actions it has taken at the international level towards realization of the right to health, as well as other economic, social and cultural rights, in developing countries.**

⁶⁷ Articles 2 (1), 11 (1) and (2), 15 (4), 22 and 23.

⁶⁸ E.g. article 4.

⁶⁹ See the Special Rapporteur's press statement of 22 June 2006, "UN health rights expert criticizes donors for failing to fulfil their humanitarian responsibilities in the Occupied Palestinian Territories".

VI. CONCLUSION

116. Throughout this report, the Special Rapporteur identifies a number of conclusions and recommendations and he will not repeat them. Here, he wishes to draw attention to two practical developments that bear upon a number of the themes that recur in this report.

1. A human rights-based approach to health indicators

117. The international right to the highest attainable standard of health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring progress, a State needs a device to measure this variable dimension of the right to health. The most appropriate device is the combined application of indicators and benchmarks. Thus, a State selects appropriate indicators that will help to monitor different dimensions of the right to health. Most indicators will require disaggregation, such as on the grounds of sex, race, ethnicity, rural/urban and socio-economic status. Then the State sets appropriate national targets or benchmarks in relation to each disaggregated indicator. In this way, indicators and benchmarks fulfil some important functions. Not least, they can help the State to monitor its progressive realization of the right to health, enabling the authorities to recognize when policy adjustments are required.

118. Because of the crucial importance of finding a way to monitor the progressive realization of the right to health, the Special Rapporteur has devoted three reports to indicators and benchmarks.⁷⁰ His last report to the Commission on Human Rights sets out a methodology for a human rights-based approach to health indicators.⁷¹ While this methodology remains work in progress, the Special Rapporteur encourages Sweden to examine and adopt this human rights-based approach to health indicators, or an approach similar to it.

119. The methodology addresses the difficult issue of the disaggregation of data. Human rights have a particular preoccupation with disadvantaged individuals and groups. While a “regular” health indicator might or might not be disaggregated, from the human rights perspective, it is imperative that all relevant indicators be disaggregated. From the human rights perspective, the goal is to disaggregate in relation to as many of the internationally prohibited grounds of discrimination as possible, such as sex, race, ethnicity, rural/urban and socio-economic status.

120. Sweden has a long tradition of collecting health data. While it is commonplace in Sweden to collect disaggregated data on various grounds, including sex and age, disaggregation on other grounds, such as race and ethnicity, is not routine. This is very significant, because the Special Rapporteur was informed that it is widely understood that

⁷⁰ Advised by numerous organizations, including WHO, and other experts.

⁷¹ E/CN.4/2006/48.

racial and ethnic minorities in Sweden have comparatively poor health status. Without data disaggregated on the grounds of race and ethnicity, how do the authorities know the scale and nature of this problem? If they do not know the scale and nature of the problem, how can they devise the most appropriate interventions? If an intervention were introduced, how would they know whether or not it was effective?

121. There are understandable sensitivities associated with the collection of some disaggregated data, such as on race and ethnicity. Such data can be misused. Appropriate ways need to be found, as they have in other countries, to address this issue. Nonetheless, with a view to gaining a clear picture of the enjoyment of the right to health across all groups in Sweden, the Special Rapporteur recommends that those responsible for data collection routinely disaggregate on a wide range of grounds, including race, ethnicity and national origin.

2. The crucial role of impact assessments

122. In 2003, the Commission on Human Rights requested the Special Rapporteur to explore the role of health impact assessments.⁷² Since then, he has looked at the issue on a number of occasions, most fully in a UNESCO-funded study of May 2006.⁷³ This study focuses on how the right to health can be integrated into environmental, social and other existing impact assessments. While on mission to Sweden, the Special Rapporteur was very interested to learn that in 2005 the Swedish National Institute of Public Health published a *Guide to Health Impact Assessments* and that the Government had recently commissioned the Institute to undertake more work in this important area. While the *Guide* is highly commendable, it does not integrate the right to health into its approach.

123. A recurrent theme in the present report is the need to integrate, in a coherent and consistent manner, the right to health across Sweden's national and international policymaking processes. Health impact assessments reflective of the right to health can contribute to such mainstreaming and policy coherence. The Special Rapporteur warmly commends all those in Sweden for their work on health impact assessments; encourages the Institute to integrate the right to health into its impact assessments; urges the Government to support such pioneering work; and encourages all parties both to use impact assessments and to ensure that these assessments take due account of the right to the highest attainable standard of health.

⁷² Resolution 2003/28, para. 16.

⁷³ P. Hunt and G. MacNaughton, *Impact assessments, poverty and human rights: a case study using the right to the highest attainable standard of health* (UNESCO, 2006).