

**“The right to health and the Millennium Development Goals
in developing countries:
A right to international assistance and cooperation?”**

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INTRODUCTION

In September 2000, world leaders adopted the *Millennium Declaration*, recognizing that, in addition to their separate responsibilities to their own societies, they “have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”¹ They reaffirmed, thus, their duty of “international cooperation in solving international problems of an economic, social, cultural or humanitarian character”², based on the principles of *solidarity* and *shared responsibility*.

In order to translate these commitments into practice, key objectives were established: peace, security and disarmament; development and poverty eradication, protection of the environment; human rights, democracy and good governance; protection of the vulnerable; and strengthening the United Nations system.³

Within the objective of eradicating poverty an ambitious pledge was made:

“We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.”⁴

In order to give focus to this ambitious vision and to provide benchmarks in the effort to achieve it, more specific aims were established and a deadline for achievement was set for 2015.⁵ Those specific aims came to be called the Millennium Development Goals (“MDGs”).

- Goal 1 – Eradicate extreme poverty and hunger
- Goal 2 – Achieve universal primary education
- Goal 3 – Promote gender equality and empower women
- Goal 4 – Reduce child mortality by two-thirds
- Goal 5 – Improve maternal health (reducing maternal mortality by three-quarters)
- Goal 6 – Combat HIV/AIDS, malaria, and other diseases
- Goal 7 – Ensure environmental sustainability
- Goal 8 – Develop a global partnership for development

In addition to actions from developing countries, developed countries were called on to adopt concrete measures such as the adoption of fair trade rules to enhance access to developed markets for exports of the least developed countries; the implementation of an enhanced programme of debt relief for the heavily indebted poor countries and the grant of *more generous development assistance*, especially to countries that are genuinely making an effort to

¹ A/RES/55/2, para 2.

² Established in the UN Charter, article 1(3).

³ Those are the eight headings into which the Millennium Declaration is divided, A/RES/55/2, para 2.

⁴ Id., para 11.

⁵ The goals established in the Millennium Declaration were further specified in the [UN Roadmap towards the implementation of the Millennium Declaration](#) (A/56/326), Report of the Secretary-General, 6 September 2001.

apply their resources to poverty reduction.⁶ One of the MDGs, moreover, is the establishment of a global partnership for development (MDG-8).

Less than ten years away from the deadline for achieving the MDGs, it has become clear that the Goals will not be reached if, as the UN Secretary General has put it, rich countries continue to “do business as usual”.⁷ To achieve the MDGs, he claims, “we must more than double global development assistance over the next few years. Nothing less will help to achieve the Goals.”⁸ This has been confirmed by the Human Development Report 2005 where it is stated that “without a renewed commitment to cooperation backed by practical action, the MDGs will be missed—and the Millennium Declaration will go down in history as just one more empty promise.”⁹

As set out in section I below, there is an emerging position in the international human rights law literature that international assistance and cooperation (“IAC”)¹⁰ is not simply a *moral duty* arising from promises such as the Millennium Declaration and others, or a mere policy decision of developed countries to help developing ones out of charity, enlightened or pure self-interest. Rather, it is claimed, it is a legal duty grounded in binding international legal instruments, most notably the UN Charter, the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights (“ICESCR”), where the obligation to implement the rights recognised therein is undertaken “*individually and through international assistance and co-operation*” (art. 2(1).)

If this position is correct, then IAC to help poor countries in their efforts to achieve the MDGs has to be taken as a right and duty¹¹ when MDGs correspond, partly or entirely, to established rights of the ICESCR and other binding human rights treaties. Moreover, MDGs (especially MDG 8 which sets the goal of a partnership for development) and other international development initiatives have to be assessed within that human rights framework. That is, international and national policies which hinder or harm economic and social rights in other countries have to be seen as a violation of the right to IAC.¹²

The aim of this paper is to explore this position further in the specific context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (the “right to health” or “the right to the highest attainable standard of health”) established in article 12 of the ICESCR. No less than four of the MDGs are directly related to health (MDGs no 4, 5, 6 and 7) and all the others are related in some way to health. Therefore, if

⁶ *Millennium Declaration* para 15, and also target 13 of MDG 8, see *UN Roadmap*, cited above at note 5.

⁷ Declaration of the UN Secretary General at the webpage of the Millennium Development Goals <http://www.un.org/millenniumgoals/> last visited on 10.4.2006.

⁸ <http://www.un.org/millenniumgoals/>

⁹ Human Development Report 2005, *International cooperation at a crossroads: Aid, trade and security in an unequal world*, At p. 2, available at <http://hdr.undp.org/reports/global/2005/>.

¹⁰ “International assistance and cooperation” is the term used in the ICESCR in article 2(1). The development literature uses many different terms which are not synonyms but are closely related to IAC, such as ODA (Official Development Assistance), development aid, development cooperation, development assistance etc.

¹¹ It is a complex debate of legal, moral and political philosophy if rights and duties are necessarily correlative, and also which side of the relation, if any, takes priority. Please see footnote 19 on this.

¹² It is important to notice, however, that the MDGs, even if correspondent to some economic and social rights, do not cover the entire spectrum of such rights recognised in the ICESCR. The right and duty of IAC, therefore, would of course not be fully realised by the achievement of those MDGs.

there is a right to and duty of IAC in the realization of economic, social and cultural rights in general, what are the implications in the specific field of the right to health? Or, to put it another way, what are the specific content and contours of the right and duty of international assistance and cooperation for the realization of the right to health. For the sake of simplicity, we will call this the right to, or the duty of international assistance and cooperation in health interchangeably, or simply the right to or duty of IAC-H.

Organisations and individuals working in the field of the right to health have increasingly made reference to IAC-H. In recent years, some individuals and organisations working on public health and development have adopted rights-based approaches. The framework of IAC is also sometimes referred to in this context.

Section I makes a legal case for IAC-H as a right, as well as an obligation on States parties. It is divided into two subsections. It starts with a brief review of the argument for a right to and obligation of IAC under the International Covenant on Economic, Social and Cultural Rights. It then considers the relationship between IAC and right to health norms and obligations. This second section explores in a preliminary manner the international dimensions of obligations derived from the right to health, including obligations of progressive realisation, core obligations, and obligations to respect, protect and fulfil this right. It also includes a focus on monitoring and accountability with respect to the right to international assistance and cooperation for the right to health (IAC-H).

Section II sets out some of the specific occasions when the Special Rapporteur on the right to health has considered the human rights responsibility of international cooperation and health. There are extracts on Niger's Poverty Reduction Strategy, Mozambique, Uganda, the US-Peru trade agreement, skills drain, mental disability and so on. Effectively, these extracts signal how the Special Rapporteur has tried to apply - or operationalise - the sort of analysis set out in section I.

PART I: THE LEGAL CASE FOR A RIGHT TO INTERNATIONAL ASSISTANCE AND COOPERATION FOR HEALTH

Introduction

There is a growing body of literature on the issue of a right or a duty of international assistance and cooperation (IAC) in international human rights law.¹³ Within the emerging debate, particular focus has been given to IAC under the International Covenant on Economic, Social and Cultural Rights (ICESCR), which includes an obligation on States to guarantee its provisions through “international assistance and cooperation”.¹⁴ As well as analysis of the application of IAC to economic, social and cultural rights in general, the Committee on Economic, Social and Cultural Rights (“the Committee”), UN Special Rapporteurs and other commentators have begun to examine its application to individual rights, including the right to health.

Section I explores some key legal sources of the obligation of IAC towards economic, social and cultural rights in general, and the right to health in particular. It also examines some of the relevant jurisprudence of the Committee, the reports of the Special Rapporteurs and work of other commentators, which add some conceptual clarity to this issue.¹⁵

International Assistance and Cooperation: Economic, Social and Cultural Rights

Legal Sources

International Treaties

¹³ Sigrun Skogly, *Beyond National Borders: States Human Rights Obligations in International Cooperation*, Intersentia, 2006; Margot Salomon, *Globalization of responsibility: interdependence and cooperation in the protection of human rights in international law*, PhD dissertation (London School of Economics, 2003); Sigrun Skogly and Mark Gibney, “Transnational Human Rights Obligations”, 24 *Human Rights Quarterly* 2002, 781-798, Sigrun Skogly, “The obligation of international assistance and co-operation in the International Covenant on Economic, Social and Cultural Rights”, in Morten Bergsmo (ed.), *Human Rights and Criminal Justice for the Down-trodden. Essays in Honour of Ashbjørn Eide*, Leiden: Martinus Nijhoff, 2003, 403-420;; Rolf Künemann, “Extraterritorial Application of the International Covenant on Economic, Social and Cultural Rights” in Coomans and Künemann in Fons Coomans and Menno T. Kamminga (eds.), *Extraterritorial Application of Human Rights Treaties*, Antwerp: Intersentia, 2004; Judith Bueno Mesquita, *International Covenant on Economic, Social and Cultural Rights: Obligations of International Assistance and Cooperation*, November 2002, on file with author, *Duties Sans Frontières*, Human Rights and Global Social Justice, International Council on Human Rights Policy (2002) available at http://www.ichrp.org/paper_files/108_w_02.doc, Magdalena Sepulveda, The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights, Intersentia, 2003, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*, OHCHR (2002), guideline 15; Koen De Feyter, *World Development Law*, Intersentia (2001); Matthew Craven, *The International Covenant on Economic, Social and Cultural Rights. A perspective on its development*, Oxford, 1998

¹⁴ ICESCR, article 2.1.

¹⁵ While this paper focuses on economic, social and cultural rights, the authors wish to acknowledge the important broader debate and developments on international assistance and cooperation, or *transboundary*, obligations in international law. For a summary of debate, see S. Skogly, and S. Skogly and M. Gibney, *supra* note 1.

Both international treaties and customary international law¹⁶ have been invoked in support of an obligation of IAC. As regards treaties, provisions in the UN Charter, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child (CRC), the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture give rise to obligations that apply beyond the territorial jurisdiction of a given State. For the purposes of this paper we shall concentrate on the provisions of the UN Charter, the Universal Declaration on Human Rights (UDHR) and ICESCR.¹⁷

The UN Charter clearly articulates a duty of international cooperation including with respect to human rights, as well as with respect to conditions - such as an adequate standard of living, employment, health and education - related to the enjoyment of economic, social and cultural rights. Article 1(3) of the UN Charter¹⁸ provides that:

The purposes of the United Nations are: ... 3. To achieve *international co-operation* in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion;

Articles 56 directs the UN members to take “[j]oint and separate action in co-ordination with the organisation for the achievement of the purposes set forth in article 55”, which states that:

With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

- a. higher standards of living, full employment, and conditions of economic and social progress and development;
- b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
- c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

The UDHR articulates that international cooperation is an entitlement, recognising:

¹⁶ In this paper, our focus is on international treaty law. For contrasting views on international customary law and IAC, see S. Skogly, *Beyond National Borders: States Human Rights Obligations in International Cooperation* (Intersentia, 2006), chapter 5; and P. Alston, “Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals,” *Human Rights Quarterly* 27 (2005).

¹⁷ For further discussions of IAC under ICESCR in general, see, for example, J. Bueno de Mesquita, *ICESCR: Obligations of International Assistance and Cooperation* (2002, on file with author); F. Coomans, “Some remarks on the extraterritorial application of the ICESCR” in F. Coomans and M. Kamminga (eds.), *Extraterritorial application of human rights treaties* (Intersentia, 2004); S. Skogly, M. Gibney, “Transnational Human Rights Obligations”, *Human Rights Quarterly* 24.3 (2002).

¹⁸The UN Charter enjoys the highest hierarchical status in international law. (art. 103)

"Everyone... is entitled to realisation, through national effort and international co-operation and in accordance with the organisation and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality," (article 22)

And that:

"Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized" (article 28).

Unlike the UN Charter and ICESCR, the UDHR is not a legally binding treaty, but can be used as an interpretative instrument and can give rise to customary law.

The ICESCR provides in article 2(1) that:

"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

Other articles in the ICESCR mention international assistance and/or cooperation in one form or another. Of particular significance is article 11, which recognises the right to an adequate standard of living, including adequate food, clothing and housing, and which provides that "*States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.*" Article 11(2), which is specifically on the right to be free from hunger, provides that this is to be achieved "*individually and through international co-operation*".

The other articles in the Covenant where international co-operation is mentioned are article 15(4) (recognising the benefits of international contacts and co-operation in the cultural and scientific fields); article 22 (allowing the Economic and Social Council to draw to the attention of UN organs and agencies matters that may assist them in deciding on international measures of assistance and cooperation) and article 23 (stating that international action includes the conclusion of conventions, the adoption of recommendations, technical assistance, regional and technical meetings).

The language used in all ICESCR provisions relating to IAC makes it clear that obligations relating to economic, social and cultural rights under the ICESCR are not restricted to the borders of the State and must involve *some form* of international assistance and cooperation. This conclusion has been supported by many commentators and has been reemphasised in a recent comprehensive study on the topic by Sigrun Skogly, where she states:

"The analysis of the sources of international human rights law obligations shows clearly that there are already existing extraterritorial human rights obligations. This is not only evident through an interpretation of treaty obligations, customary

international law and general principles of international law, but has also been confirmed by international courts and committees.”¹⁹

However, those treaty provisions and other sources are less clear on the *exact form* that international assistance and cooperation shall take, and how States will be made accountable for their breaches of those obligations. This is the challenge we now face, although these questions are increasingly being analysed by various commentators and actors. We turn to those two important issues in the following sections.

Soft law and academic commentary

The clarification of the scope of obligations of international assistance and cooperation has been advanced recently by the work of the Committee on Economic, Social and Cultural Rights (CESCR), Special Rapporteurs – including the Special Rapporteurs on the right to the highest attainable standard of health, adequate food and adequate housing²⁰ - and also by legal commentators. As stated by Margot Salomon, “[m]any of the specific parameters pertaining to the duty of international cooperation are not very clearly drawn. However, a perceptible shift is taking place in which the international law of human rights is seeking to inform its scope and content.”²¹

The CESCR, the body entrusted with monitoring the Covenant and interpreting its provisions, has emphasized that there is a duty of IAC. The Committee has also, to some degree, clarified the nature of this obligation, through its General Comments²² and Concluding Observations on States parties’ reports.

General Comment no 3 on the nature of State party obligations (1990) importantly emphasizes the Committee’s view that IAC is an obligation on States parties:

“The Committee wishes to emphasize that in accordance with Articles 55 and 56 of the Charter of the United Nations, with well-established principles of international law, and with the provisions of the Covenant itself, international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others in this regard. ... It emphasizes that, in the absence of an active programme of international assistance and cooperation on the part of all those

¹⁹ Skogly (2006), at 202.

²⁰ The work of Special Rapporteurs, in particular the Special Rapporteur for the right to the highest attainable standards of health, will be discussed below under International Assistance and Cooperation for Health and in section II.

²¹ Margot Salomon, “International Human Rights Obligations in Context: Structural Obstacles and the Demands of Global Justice”, in in Stephen.P. Marks and Bard Anders Andreassen (Eds.), *Development as a Human Right: Legal, Political and Economic Dimensions* (Harvard University Press, forthcoming 2006)

²² General Comments are interpretive statements issued by the Committee on specific provisions in an attempt to clarify the nature and scope of rights and obligations under ICESCR. They are what is usually called “soft law” in international law (i.e. they are non-binding), as opposed to “hard law” such as the Covenant and other treaties, which are legally binding. While General Comments are non-binding, they are nevertheless recognised as having significant legal weight and offering jurisprudential insights into the rights enumerated in the ICESCR.

States that are in a position to undertake one, the full realization of economic, social and cultural rights will remain an unfulfilled aspiration in many countries."²³

The General Comments and Concluding Observations emphasise that the obligation is relevant in a range of contexts, from the level of international development assistance, to policy or programme decisions of inter-governmental organizations or bilateral development agencies affecting economic, social and cultural rights.

Box I: A selection of CESCR's Concluding Observations regarding IAC

“The Committee encourages the State party, as a member of international financial institutions, in particular the International Monetary Fund 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 under the Covenant, in particular with the obligations contained in articles 2.1, 11.2, 15.4 and 23 concerning international assistance and cooperation.” (*CESCR, Concluding Observations on the United Kingdom, 2002, UN doc. E/C.12/1/Add. 79, para. 26*)

“The Committee recommends that the State party continue its activities in the area of international cooperation and increase its ODA to 0.7 per cent of its GDP, as recommended by the United Nations. The Committee also urges the State party to take into account the provisions of the Covenant in its bilateral project agreements with other countries.” (*CESCR, Concluding Observations on Italy, 2004, UN doc. E/C.12/1/Add.103, para. 34.*)

“The Committee strongly recommended that the State Party's obligations under the Covenant should be taken into account in all aspects of its negotiations with international financial institutions, such as IMF, the World Bank and WTO, to ensure that economic, social and cultural rights, particularly of the most vulnerable groups, are not undermined.” (*CESCR, Concluding Observations on Egypt, 2000, UN doc. E/C.12/1/Add.44, para. 28.*)

“The Committee strongly recommends that the State party's obligations under the Covenant should be taken into account in all aspects of its negotiations with the international financial institutions and other regional trade agreements to ensure that economic, social and cultural rights, particularly of the most disadvantaged and marginalized groups, are not undermined.” (*CESCR, Concluding Observations on Ecuador, 2004, UN doc. E/C.12/1/Add.100, para. 56*)

IAC – an obligation on whom?

The Concluding Observations and General Comments indicate that the Committee considers that IAC encompasses a duty on developing states to seek IAC. For example, the

²³ *Id.*, paragraph 14.

Committee's Concluding Observations on Egypt and Ecuador urge these States to take account of their obligations under ICESCR in the context of negotiations with international financial institutions and in the field of international trade (see box 1). Having entered into binding international commitments towards ESCR, the point that the Committee is making is that these States have an obligation to guarantee these rights in and through international policy processes. They can and should make use of their binding obligations to protect the rights and interests of their populations.²⁴

As well as a duty on developing countries to seek IAC, ICESCR equally gives rise to an obligation on developed States to engage in IAC. This is evident in the Committee's Concluding Observations including in relation to the UK and Italy, where the Committee urges these States to commit 0.7 percent GDP to international development assistance, and guarantee, so far as possible, that as members of the international financial institutions, that the policies of these institutions are consistent with the Covenant (see box 1).

IAC – a right and an obligation

It is a complex debate of legal, moral and political philosophy if rights and duties are necessarily correlative, and also which side of the relation, if any, takes priority. We are not going to venture in this debate here.²⁵ We are assuming in this paper that if there is a duty of IAC there is a corresponding right to IAC and vice-versa, and will use either expression depending on the context. They are, so to speak, two sides of the same coin. In legal discourse this is the dominant position.²⁶ Human rights obligations derive from rights. If IAC is an obligation on States, it is logical to conclude that IAC is also an element of each right enumerated in the Covenant. Thus it should be possible to speak of a right to international assistance and cooperation for health.²⁷

That IAC is a right is also supported by the provisions of the Universal Declaration on Human Rights, which recognises, among others, that: *"Everyone ... is entitled to realization, through national effort and international cooperation ... of the economic, social and cultural rights indispensable for his dignity and free development of his personality"* (article 22). It is also the position

²⁴ For a further discussion on the argument that developing States should use the Covenant as a shield, see P. Hunt, "Using Rights as a Shield", *Human Rights Law and Practice* 6.2 (2002).

²⁵ For a good discussion of this point, see the seminal paper by David Lyons, "The Correlativity of Rights and Duties", *Nôus*, vol. 4, n. 1, 1970, pp. 44-55.

²⁶ It is unusual in legal discourse to claim the existence of duties without a corresponding right and vice versa. As famously put in *Salmond on Jurisprudence*, one of the classic English textbooks on legal theory, "there can be no right without a corresponding duty, or duty without a corresponding right, any more than that can be a husband without a wife, or a father without a child" (11th ed., at 264, quoted in Lyons, at 48). It is also worth making clear that we use the terms duty and obligation interchangeably throughout this paper.

²⁷ Some commentators are wary of speaking of IAC in the language of rights. This position has been raised in the Workshop "Realising the right to health and the Millennium Development Goals in the South: A legal obligation for Northern States?", held at the British Medical Association, 19 April 2006. Given the workshop was held under the Chatham House Rule, we cannot attribute the position, but the underlying rationale for it seems to be that the language of rights, more than that of duties, implies the possibility of claims by the right-holders and that might jeopardize the movement towards more IAC. It is therefore a pragmatic, not a conceptual point.

taken by the three authors of OHCHR's *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*.²⁸

International Assistance and Cooperation: The Right to Health

In recent years, the Committee has fleshed out the nature and scope of IAC in relation to specific rights, including the rights to housing, health, food, education and water.²⁹ To some degree, these efforts have clarified the relationship between IAC, particular norms, and different aspects of the conceptual framework of obligations on States under the Covenant. Other actors have also made contributions in this context. For example, the Special Rapporteur on the right to health has applied IAC as a cross-cutting issue throughout his reports, exploring it in the context of issues such as sexual and reproductive health rights, mental disability, the Millennium Development Goals, the skills drain and international trade agreements bearing on the right to health. The Special Rapporteur on the right to food, Mr Jean Ziegler, has also given considerable attention to the issue of IAC, including in his 2005 report to the Commission on Human Rights which contained an important chapter on “extra-territorial obligations of States to the right to food”.³⁰

Drawing on the work of CESCR, the Special Rapporteur on the right to the highest attainable standard of health, and other actors, the remainder of section I explores the relationship between IAC and right to health norms, and the relationship between IAC and the conceptual framework of obligations relating to the right to health, including obligations of *respect, protect, and fulfilment*, obligations of progressive realization, and minimum core obligations. Section II then sets out how the Special Rapporteur has approached IAC-H in a selection of his reports, for example, in relation to Mozambique, Uganda, Peru, countries acceding to the World Trade Organisation, mental disability, the skills drain, and other issues.

Right to Health Standards and Norms, and their Relationship to IAC-H

The right to the highest attainable standard of health is protected in international human rights treaties including ICESCR (Article 12), the Convention on the Elimination of All Forms of Racial Discrimination (Article 5), the Convention on the Elimination of All Forms of Discrimination Against Women (Article 12) and the Convention on the Rights of the Child (Article 24). These provisions are open ended. However, in recent years, greater clarity about the right to health has been achieved through the General Comment on the right to health of the Committee on Economic, Social and Cultural Rights, the work of the Special Rapporteur on the right to the highest attainable standard of health,³¹ and the work of other treaty bodies, organisations and individuals.³²

²⁸ P. Hunt, M. Nowak, S. Osmani, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (OHCHR, 2002).

²⁹ See CESCR General Comments 4, 14, 12, 13 and 15, respectively.

³⁰ 25 January 2005, UN doc. E/CN.4/2005/47.

³¹ See, for example, preliminary report of the Special Rapporteur to the Commission on Human Rights, UN doc. E/CN.4/2003/58.

³² See, for example, General Recommendation No 24 on Women and Health of the Committee on the Elimination of Discrimination Against Women (1999); World Health Organization, *25 Questions and Answers on*

It is now possible to confirm the following key features of the right to health:

- The right to health is “a right to the enjoyment of a variety of facilities, goods and services and conditions necessary for the realisation of the highest attainable standard of health”,³³
- The right to health contains both general freedoms and entitlements, including: freedom to control one’s health and body; freedom from non-consensual medical treatment and experimentation; and an entitlement to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health;³⁴
- The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, 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;³⁵
- The right to health can be broken down into more specific entitlements, such as the rights to: health facilities, goods and services; prevention, treatment and control of diseases; maternal, child and reproductive health; and healthy natural and workplace environments;³⁶
- Non-discrimination and equal treatment are among the most critical components of the right to health. International human rights law proscribes any discrimination in access to health care and the underlying determinants of health on the internationally prohibited grounds, such as sex, ethnicity and health status;
- The right to health includes the active and informed participation of individuals and communities in decision-making that bears upon their health. In other words, the right not only attaches importance to health outcomes, but also to the processes by which they are achieved;
- Accountability is a vital element of the right to health. Like all human rights, the right to health grants entitlements to some (ie individuals and communities) and places legal obligations on others (ie primarily states). By emphasising obligations, it requires that all duty-holders be held to account for their conduct.

Health and Human Rights, 2003; J. Asher, *The Right to Health: A Resource Manual for NGOs* (AAAS/COMMAT, 2004).

³³ General Comment No. 14, para. 9.

³⁴ General Comment No. 14, para. 8.

³⁵ General Comment No. 14, para. 11.

³⁶ General Comment No. 14, paras. 13-17.

- Finally, the right to health extends to international assistance and cooperation, in other words, IAC-H. This means that developed states have some responsibilities towards the realisation of the right to health in developing countries.

The right to IAC-H includes freedoms and entitlement that should be read into all right to health norms. For example, the right to health includes entitlements to health facilities, goods and services - including through international assistance and cooperation. To take another example, the right to health includes informed and active participation in international decision making processes that bear upon health. Furthermore, the right to health includes non-discrimination and equality in and through policies and programmes of IAC-H.

In his work, the Special Rapporteur on the right to health has emphasised that the right to health can be understood as: “a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.”³⁷ This interpretation draws on right to health norms under ICESCR.³⁸ This has important implications for IAC-H. For example, donor or international organization health interventions should, where possible, support health systems through interventions which are integrated into or strengthen the system.

Some examples of the application of IAC-H to particular norms and health systems are explored in Section II of this paper.

The Nature of Obligations on States Parties

In 2004, the United Nations Development Programme published a country study “UK Financing of International Cooperation for Health.”³⁹ The report highlights the very wide range of UK policies that bear upon health in developing countries, including trade policies, overseas development assistance (including policies and the level of assistance), funding of multilateral institutions, controls on international recruitment of health professions, and tax incentives for research into neglected diseases. In the view of the authors, this wide-ranging study provides a useful checklist of policy areas which may be relevant in the context of IAC-H.

The Committee on Economic, Social and Cultural Rights has already emphasized that IAC-H applies in relation to a wide range of policy contexts discussed in the UNDP paper, including provision of aid, concluding international agreements, and within the context of their membership of international financial institutions:

“States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. States parties should ensure that the right to health is given due attention in

³⁷ E/CN.4/2006/48, para. 4.

³⁸ The approach is also supported by analysis of the importance of health system strengthening, including, among others, WHO, *World Health Report 2003 – Shaping the Future*; L. Freedman, M. Wirth et al, *Whose Got the Power: Transforming Health Systems for Women and Children* (2005).

³⁹ G. Lister, A. Ingram, M. Prowle, *UK Financing of International Cooperation for Health* (UNDP: 2004).

international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.”⁴⁰

In other words, IAC-H should be read as applying across the spectrum of national or international policies that may affect health in other countries. One of the major obstacles to IAC-H is that these international policy contexts involve a range of Government ministries, including foreign affairs, finance/treasury, health, overseas development agency, and justice. Officials from some of these ministries are unlikely to be familiar with the nature and scope of their obligations under international human rights law, including IAC-H.

The next paragraphs explore in a preliminary manner the nature of obligations on States towards the right to IAC-H. The paragraphs draw on, among others, the approach of CESCR, which has set out obligations relating to the right to health in terms of progressive and immediate obligations, and obligations to respect, protect, and fulfil the right to health.

Respect, protect, fulfil

Under ICESCR, States have a tripartite obligation towards the right to health: to *respect* (ie do no harm); *protect* (prevent others from harming); and *fulfil/facilitate* (undertake actions that contribute towards the realization of) the right to health. The Committee spells out in General Comment 14 that that these obligations to respect, protect, and facilitate the right to health apply in the context of IAC-H:

“States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.”⁴¹

There is little further specification within the General Comment, however, of what each of those three dimensions might entail. As to the obligation to respect, the Committee urges States parties to, for example, “*refrain at all times from imposing embargoes or similar measures*

⁴⁰ General Comment No. 14, para. 39.

⁴¹ General Comment No. 14, para. 39,

*restricting the supply of another State with adequate medicines and medical equipment.”*⁴² Other contexts where the obligation to respect may arise includes, for example, intellectual property clauses in trade negotiations, where States should respect the right to access essential medicines in States with which they are negotiating.

No specific examples are given in the General Comment of obligations to protect in relation to IAC-H. However, some guidance may again be sought from the analysis of the UN Special Rapporteur on the right to the highest attainable standard of health. For example, in a report on the international health worker skills drain, the Special Rapporteur emphasizes that, as part of this obligation, “*States should regulate private recruitment agencies that operate internationally with a view to ensuring that they do not recruit in a manner that reduces a developing country’s capacity to fulfil the right to health obligations that it owes to those within its jurisdiction.*”⁴³

With respect to the obligation to fulfil, the Committee emphasizes that “[d]epending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required”⁴⁴ Within the context of fulfil obligations, the Committee has recommended to developed States that they commit 0.7 per cent GDP to development assistance, in line with the United Nations target. The Committee, and the UN Special Rapporteur have also urged States to commit adequate resources through aid, and pursue other relevant policies, towards the implementation of the Millennium Development Goals. As put in the most recent report of the UN Special Rapporteur:

“In summary, North and South must, as a matter of urgency, take concerted measures to establish effective, inclusive health systems accessible to all, in developing countries and economies in transition, in line with the United Nations Millennium Declaration, the global partnership for development reflected in Goal 8 of the Millennium Development Goals, and the 2005 World Summit.”⁴⁵

It seems uncontroversial that the duty to fulfil the right to health and other economic and social rights remains primarily with the national State. It is primarily when a country’s own resources are insufficient for the realisation of the right to health that the duty on donor states to fulfil IAC-H arises. To mark this subsidiary nature of the duty, the Special Rapporteur on the right to food refers to it as a duty to “support to fulfil”.⁴⁶ Of course, assessing the (in)ability of a national state to fulfil the right to health is a complex affair, but this discussion lies beyond the parameters of this paper.

Progressive realization, availability of resources and immediate obligations

The principle of progressive realisation⁴⁷ acknowledges that the realisation of all economic, social and cultural rights is impossible to achieve instantaneously (e.g. due to resource

⁴² Id., para 41.

⁴³ A/60/348, para. 61.

⁴⁴ General Comment 14, para. 39.

⁴⁵ E/CN.4/2006/48, para. 17.

⁴⁶ *Report of the Special Rapporteur on the Right to Food, Jean Ziegler*, 24 January 2005, UN Doc. E/CN.4/2005/47, para. 47.

⁴⁷ ICESCR, article 2.1.

limitations) and allows for realisation over a period of time. In addition to progressive realization, States have some immediate obligations. This includes non-discrimination, the obligation to take concrete and targeted steps towards progressive realization, and the meeting of certain “core obligations”.

If a country has not achieved the full realisation of the right to health, this does not necessarily mean that other, richer, States have an obligation to give assistance and resources in this regard. The Committee on Economic, Social and Cultural Rights has emphasised that IAC-H is particularly incumbent with respect to immediate obligations, including core obligations.

Core obligations

In its General Comment 14 on the right to health, the Committee explains its understanding of core obligations with respect to the right to health:⁴⁸

“43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give

⁴⁸ For a fuller discussion of core obligations, see A. Chapman, S. Russell, *Core Obligations: Building a Framework for Economic, Social and Cultural rights* (Intersentia, 2002).

particular attention to all vulnerable or marginalized groups.”⁴⁹

In the view of the Committee, there is a particularly close relationship between IAC and core obligations. The Committee has emphasised that “[w]hen grouped together, the core obligations establish an international minimum threshold that all developmental policies should be designed to respect,”⁵⁰ and that “it is particularly incumbent on States parties and other actors in a position to assist, to provide ‘international assistance and cooperation, especially economic and technical’ which enable developing countries to fulfil their core and other obligation.”⁵¹

This is important. While core obligations are supposedly set at a low level, within the reach of all States, the reality is that many developing countries do not have the resources to meet core obligations. In 2001, the report of the Commission on Macroeconomics and Health (CMH) emphasized that:

“Even if poor countries allocated more domestic resources to health, such measures would still not resolve the basic problem: poor countries lack the needed financial resources to meet the most basic health needs of their populations.”⁵²

According to the estimates of the CMH, low income and least developed countries need between US\$ 30 and US\$45 *per capita* per year to finance a selection of 49 priority health interventions. Even though the CMH did not use the language or framework of core obligations related to the right to health in the selection of those interventions, there is a significant correspondence between the CMH health interventions, the core obligations of GC 14, and also the Millennium Development Goals.⁵³

In the 48 least developed countries the average expenditure in health in 1997 was US\$11 *per capita* per year (including an average of US\$2.29 backed by donors from the international community), that is, at least US\$24 less than required to achieve the basic health system mentioned. The same study predicts that by 2007 those countries could be able to increase that expenditure by a 1% of their GNP, reaching US\$15 *per capita* per year.⁵⁴

Clearly, therefore, there is a significant role for developed States in relation to IAC-H if core obligations are to be met in developing countries. The CMH estimated that in order to fulfil

⁴⁹ CESCR, General Comment No. 14, para. 43.

⁵⁰ CESCR, Statement on Poverty and the International Covenant on Economic, Social and Cultural Rights, para 17.

⁵¹ General Comment 14, para. 45.

⁵² WHO Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development*, December 20, 2001, at 56-57. Available at http://www3.who.int/whosis/cmh/cmh_report/e/pdf/157-176.pdf (Retrieved February, 15 2006).

⁵³ Rachel Hammonds and Gorik Ooms, “World Bank Policies and the Obligation of its Members to Respect, Protect and Fulfill the Right to Health” *Health and Human Rights*, vol. 8, no. 1, (2004) pp 26-60, at 41. The interventions recommended by the CMH are directed towards TB treatment, malaria and HIV/AIDS prevention, HIV/AIDS care, HIV/AIDS HAART, maternal conditions-related interventions (ante- and intra-partum) and prevention and care of childhood-related diseases.

⁵⁴ CMH report., *Appendix 2: Analysis of the Costs of Scaling Up Priority Health Interventions in Low and Selected Middle-Income Countries*.

its basket of priority interventions total donor spending relating to health would need to be \$27 billion in 2007 and \$38 billion in 2015. This would represent a significant rise from the \$6 billion donor spending on health in 2001, although the CMH estimates that the increase would be manageable.⁵⁵ Recent donor pledges on aid, including the commitment made by G8 leaders to increase aid to developing countries by \$50 billion by 2010 are a welcome step in the right direction to progressively realize IAC-H.

Monitoring and Accountability

Human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Monitoring and accountability is vital to this exercise. Unless supported by a system of accountability, human rights can become no more than window-dressing.

While it is commonplace for the impact of health policies to be monitored, it is less common for health policies to be assessed against a right-to-health standard and for those responsible for the policy to be held to account for the discharge of their duties arising from the right to health.

Specific human rights and general accountability mechanisms can be utilised to hold duty bearers to account for obligations towards the right to health. By specific mechanisms, this paper refers to formal human rights accountability mechanisms, such as courts, national human rights institutions or ombuds, parliamentary scrutiny of human rights, UN treaty bodies and Special Rapporteurs. By general mechanisms, this paper refers to accountability mechanisms which are not explicitly focused on human rights, but which may be used to hold duty bearers to account indirectly for human rights, such as social or environmental impact assessments, parliamentary scrutiny of international development policy, and elections.

The traditional model of human rights accountability involves holding a State accountable for human rights within its jurisdiction. While under the majority of international human rights treaties States have some degree of extraterritorial obligation, there are relatively few examples where individuals have sought to hold States to account in this regard. Even so, there is a growing jurisprudence, as well as growing awareness by civil society of the range of possible avenues for holding duty-bearers to account for IAC-H.

The use of indicators and benchmarks have an important role to play in monitoring progressive realization of the right to health. To date, limited attention has been paid to indicators for IAC-H, although the Special Rapporteur has explored this issue in a preliminary fashion (see Section II).

⁵⁵ Of course, any increases in donor expenditure on health should not be at the expense of other human rights, such as the rights to food, education, water and housing. Increasing assistance for these other economic, social and rights is also required by many donors.

The following paragraphs include some non-exhaustive, illustrative examples of formal and informal national and international mechanisms, and how they have been used or could be used to hold duty bearers to account for IAC-H.

International level – formal human rights accountability mechanisms

At the international level, the UN treaty monitoring bodies, such as the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child (CRC), as well as the UN Special Rapporteur on the right to health, are avenues for holding States to account for IAC-H.

The treaty bodies' State party reporting processes provides important opportunities for formally holding States parties to account for their IAC-H obligations. CESCR, for example, has consistently made IAC-related recommendations in its Concluding Observations on the State party reports of developed States (see Box 1 above), and discussed IAC in its "constructive dialogue" with State party representatives whilst reviewing the given State's report. Both CESCR and CRC have made recommendations in Concluding Observations to developing countries that they mainstream their human rights obligations towards economic, social and cultural rights in international policy negotiations, including with international financial institutions and in the context of international trade agreements (see Box 1 above).

The State party reporting process provides opportunities for civil society engagement to hold duty-bearers to account. Civil society organisations can submit "shadow reports" in relation to States parties' reports, which provide an alternative view of a given State's compliance with its international human rights obligations. They are also invited to participate indirectly in the Committees' sessions when they review State party reports. In recent years, NGOs have started to submit shadow reports on IAC, including IAC-H. For example, in 2001 Brot für die Welt, the Church Development Service (Evangelischer Entwicklungsdienst - EED) and FIAN International presented a first parallel report on Germany's extraterritorial obligations to the CESCR.⁵⁶ The NGO 3D-Three has also submitted a number of shadow reports to CESCR, CRC and the Human Rights Committee on countries including Italy, Denmark, Uganda, Ecuador, Thailand, Botswana and the Philippines, focusing on the impact on the right to health of international trade negotiations undertaken by these States.⁵⁷ The reports of FIAN and 3D-Three seem to have been influential in that the Concluding Observations of the UN treaty bodies have on almost all occasions included recommendations closely based on the information provided by these NGOs.⁵⁸

The Special Rapporteur on the right to health has also acted on a number of occasions to hold States to account for IAC-H – some of which are highlighted in Section II of this paper.

⁵⁶ See Brot für die Welt, the Church Development Service (Evangelischer Entwicklungsdienst - EED) and FIAN International, *Extraterritorial State Obligations: ICESCR - Parallel Report Compliance of Germany with its International Obligations Under ICESCR* (2001).

⁵⁷ The briefings can be downloaded from <http://www.3dthree.org/en/page.php?IDpage=23>

⁵⁸ See, for example, 3D-Three, *UN Human Rights Monitoring Treaty Bodies Review of State Implementation of International Conventions: References to Intellectual Property and Human Rights* (undated).

In brief, the Special Rapporteur undertakes two formal country missions a year, with the objective of monitoring the progressive realisation of, and making constructive recommendations for, the right to health in those states. The missions culminate in a report submitted to the UN. In his country reports on Peru, Uganda and Mozambique, the Special Rapporteur has consistently addressed and made recommendations with respect to IAC-H. For example, in his Peru mission report, he noted with regret the termination of a bilateral programme on health and human rights funded by DFID due in part to reallocation of resources to fund the reconstruction of Iraq.⁵⁹ To its credit, DFID subsequently found funds to continue some support for its Peru programme. In January 2006, the Special Rapporteur undertook a country mission to Sweden. One of the objectives of the mission was to assess Sweden's international policies and their impact on the right to health in developing countries.⁶⁰

The Special Rapporteur also sends communications to States parties in response to information received alleging violations of the right to health – in other words, with a view to holding States to account where violations have arisen or may arise. He has written several communications expressing his concern about intellectual property protections negotiated in the context of bilateral or multilateral trade negotiations where protections may hamper access to essential medicines.⁶¹

International level – general accountability mechanisms

As well as the formal human rights accountability mechanisms, other mechanisms may also be used to implicitly hold duty-bearers to account more generally, in a manner that can support IAC.

For example, the “peer review” process of the Development Co-operation Directive (DAC), Organisation for Economic Co-operation and Development (OECD), provides an opportunity for scrutinising development assistance of OECD members, including in relation to health. A report is made on each OECD member every four years. The report is prepared by the secretariat, and officials from 2 DAC members, and based on consultations with officials, parliamentarians, civil society and field visits to recipients of aid. Human rights commitments of donors are not consistently given attention in the peer review process,⁶² although references to human rights are certainly found in peer review reports. The process provides an important opportunity to hold donors to account for policies and programmes that have an impact on IAC-H, even if IAC-H is not explicitly within the framework of the peer review process.

⁵⁹ E/CN.4/2005/51/Add.3, para 40.

⁶⁰ The Special Rapporteur's report will be submitted to the UN Human Rights Council in 2006. For some preliminary findings, see preliminary remarks of the Special Rapporteur on his visit to Sweden, 19 January 2006, available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/Sweden%20press%20conference%20remarks%2021January%202006.doc.

⁶¹ See, for example, E/CN.4/2006/48/Add.1, paras. 24 and 63-65.

⁶² See LH Piron, *Integrating Human Rights into Development: A Synthesis of Donor Approaches and Experiences* (ODI, 2005).

The World Bank group also has several accountability mechanisms which may provide an avenue for holding States to account indirectly for IAC-H. For example, recently a case was filed with the Compliance Advisor Ombuds in relation to an International Finance Corporation (IFC) and Multilateral Investment Guarantee Agency (MIGA) financed project of what would be the largest papermill in Uruguay. Although the mill has potential right to health implications, the case hinges on issues bearing on the explicit policies and procedures of IFC and MIGA, including the quality of the IFC-sponsored social and environmental impact assessments, and allegations that the concerns of local communities were not taken into account.⁶³ A case against Uruguay on the same project has also been filed at the Inter-American Commission on Human Rights.

National level – formal human rights accountability mechanisms

So far as the authors are aware, there are no national human rights mechanisms which have an explicit mandate to monitor IAC-H in developing or developed countries. However, there are certainly a number of human rights accountability mechanisms which may potentially be used for this purpose.

For example, in the UK, the Joint Committee on Human Rights routinely convenes inquiries on the UK Government's response to UN treaty body concluding observations, with respect to their terms of reference to consider "matters relating to human rights in the United Kingdom". In 2003, the Joint Committee organised a hearing on the UK Government's response to the CESCR Concluding Observations on the UK's 4th Periodic Report under the ICESCR.⁶⁴ While the hearing did not consider matters relating to the UK's international policies on this occasion, in future the Joint Committee could be lobbied to take up this course of analysis.

To take another example, the Special Rapporteur on the right to the highest attainable standard of health has suggested the establishment of National Offices to monitor international cooperation in health.⁶⁵ Also, in the report on his mission to Uganda, he recommended that the National Human Rights Commission of Uganda should undertake a project to monitor policies and programmes relating to neglected diseases, and should monitor and hold to account relevant national and international actors, both public and private (see Section II).⁶⁶

National level – general accountability mechanisms

Other national forms of accountability mechanism, which may not be framed in terms of human rights, might also have an important role to play for indirectly holding States to account for IAC-H. The Government of Sweden, for example, recently established an independent unit to evaluate Sweden's international development cooperation.⁶⁷ And in

⁶³ D. Taillant, *Using Human Rights Tribunal to Force Bank Compliance: Uruguayan Paper Mill*, Bretton Woods Project Update 49, January 2006.

⁶⁴ See Joint Committee on Human Rights Twenty First Report, published 2004.

⁶⁵ Report to the GA, A/60/348, at paras 71 and 86 to 88.

⁶⁶ Report to the Commission on Human Rights, E/CN.4/2006/48/Add.2, paras. 92-93.

⁶⁷ Forordning om instruction for Institutet for utvardering av internationellt utvecklingssamarbete, 15 December 2005.

many donor countries parliamentary procedures are in place to examine development agencies' policies – in the UK the International Development Committee holds DfID to account for its policies. Social and environmental impact assessments may also play an important role in holding duty bearers to account. For example, in June 2005, the Peruvian Ministry of Health published an assessment of the likely impact on access to essential medicines (a right to health entitlement) of a possible free trade agreement with the United States.⁶⁸

Conclusion

While there are numerous explicit human rights and general accountability mechanisms – at the national and international levels - that may provide avenues for accountability for IAC-H, they have generally been underutilised for this purpose. This may be because of a lack of awareness about procedures that may be used to hold duty bearers to account. It may also be because there is scepticism about whether these mechanisms will prove effective for operationalising IAC-H, or for guaranteeing redress where there has been an abuse of the right to IAC-H. Effectiveness is often crudely equated with the clout of an accountability mechanism, and the accountability mechanisms described in this paper cannot force Governments or others to comply with their findings. Yet the mechanisms can even so be very effective. The will of the Government, and organisation and determination of civil society are among the important variables in this respect.

⁶⁸ In his mission report on Peru, the Special Rapporteur on the right to health had recommended that the Government of Peru undertake such an impact assessment.

PART II: IAC-H: THE APPROACH OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Introduction

This section sets out some of the specific occasions when the Special Rapporteur on the right to health has considered the human rights responsibility of international assistance and cooperation in his reports.

There are extracts on Niger's Poverty Reduction Strategy, Mozambique, Uganda, acceding countries to the World Trade Organisation, the US-Peru trade agreement, mental disability, the skills drain, and indicators for measuring IAC-H.

Effectively, these extracts signal how the Special Rapporteur has tried to apply - or operationalise - the sort of analysis set out in the first section of this paper. Inevitably, there is some repetition amongst the extracts. We have added brief commentaries in italics at the beginning of each extract and also at the end of the last one.

We acknowledge that others have also sought to apply the human rights concept of international assistance and cooperation in the health context. Take, for example, the important work of non-governmental organisations, such as Medact, Global Health Watch, Save the Children (UK), and 3 D, as well as CESCR and CRC. Indeed, these – and others like FIAN and the Special Rapporteur on the right to food – have influenced the interventions of the Special Rapporteur on the right to health.

Nonetheless, in this section, we focus on the work of the Special Rapporteur on the right to health. It is not offered as a model, but as a body of work to critique.

What light, if any, do the following extracts shed on IAC-H? Does this body of work deepen the practical application of IAC-H? What lessons can be learnt from this work? What should the Special Rapporteur do by way of next steps in this domain? What can and should others do to advance IAC-H?

Among the issues that stand out from the following extracts (and the literature generally), two deserve particular emphasis.

First, there is no shortage of good and bad practices of IAC-H. While developed states may resist the notion of a *legal* obligation of IAC, they have multiple policies, programmes and projects that are otherwise reflective of IAC-H. Perhaps, therefore, a key way forward is to gather a collection of good and bad IAC-H practices.

Second, as clearly signalled in section I of this paper, monitoring and accountability mechanisms, at the national and international levels, are urgently needed in relation to IAC-H. This is an area that needs most urgent attention.

As section I of this paper emphasises, the human rights concept of international assistance and cooperation extends to a range of economic, social and cultural rights. It is important that developments in relation to IAC and health are consistent with and reinforce developments in relation to IAC and food, education, shelter and so on. These are not isolated exercises, they are inter-linked. Also, IAC bears upon the right to development. Thus, the connections (and differences) between IAC-H and other contemporary issues need consideration.

Nonetheless, we suggest that the time has probably come when progress in relation to IAC will not be made at the general level ie by talking generally about IAC in relation to all economic, social and cultural rights. Rather, the time has probably come when progress in relation to IAC will be made by looking at IAC in relation to specific sectors or rights – albeit in a way that recognises that all rights, and many sectors, are interconnected.

Accordingly, the following extracts on IAC-H merit attention.

Niger's Poverty Reduction Strategy

In 2002, the Government of Niger prepared a Poverty Reduction Strategy (PRS) in the context of the Heavily Indebted Poor Countries Initiative. At a meeting in Niamey, the Special Rapporteur presented some preliminary comments, from the point of view of the right to health, on some health-related aspects of the PRS. In a subsequent UN report, he briefly signalled five illustrative issues from the PRS that merit further attention from the right to health perspective.⁶⁹ One of these issues concerned international assistance and cooperation, another monitoring and accountability. Both are extracted below.

International assistance and cooperation

69. In his previous reports, the Special Rapporteur remarks on the human rights concept of international assistance and cooperation which can be traced from the Universal Declaration of Human Rights, through to binding human rights treaties, such as ICESCR and the Convention on the Rights of the Child, and which resonates with recent world conference outcomes, including the Millennium Declaration.
70. The enormous scale of the health problem confronting Niger is relevant to the human rights concept of international assistance and cooperation. The PRS acknowledges Niger's "alarming health situation with a mostly illiterate population; a constantly deteriorating environment with an impoverished economy". (4.2.3.3.3.) It remarks that Niger has "provided the private sector with every opportunity to play the lead role, namely in the areas of production and commercial activities. Unfortunately, it is not yet dynamic enough to take over." (4.1.3.4) Significantly, it observes that two of the health-related MDGs - reduction of maternal mortality by three quarters and reduction of child mortality by two thirds - "seem unrealistic for Niger". (3.3.3.2) In other words, it is clear from the PRS that Niger will not be able to realise even the minimum essential levels of the right to health in the foreseeable future without very considerable and sustained international assistance and cooperation. In 2002, the Joint Staff Assessment of the IMF and World Bank endorsed Niger's PRS and concluded: "the current gaps in implementation capacity

⁶⁹ E/CN.4/2004/49, 16 February 2004 – the footnote has been deleted from the extract.

will require that external partners step up their technical assistance support in line with PRSP priorities." (para 34)

71. Of course, this does not divest the Government of Niger of its responsibility to do all in its power to realise the right to health for all those in its jurisdiction. Clearly, the Government could do more to promote the right to health. For example, between 1994-2000 Niger earmarked only 6% of its budget for health, well below the 10% recommended by WHO. (1.2.2.3.5) However, the point is that, as reflected in international human rights law and the Millennium Declaration, both the Government and its bilateral and multilateral partners have responsibilities in relation to the right to health in Niger.
72. As the PRS puts it: "Development partners share equal responsibility with Niger authorities for achieving the ambitious goals set by the Millennium Declaration." (4.1.3.5) In these circumstances, it would seem appropriate for Niger's PRS to refer not only to the Millennium Declaration, but also the human rights concept of international assistance and cooperation. It is on the basis of such a normative framework that a realistic, balanced and equitable sector-wide approach to health in Niger can be constructed.

*Monitoring and accountability
(deletions)*

74. The PRS candidly acknowledges that its monitoring and evaluation mechanisms need strengthening (page 11 and para 6.1). Importantly, monitoring and accountability mechanisms are needed in relation to both national (eg Government) and international actors (eg bilateral and multilateral partners). Moreover, these mechanisms should be developed with the active participation of stakeholders including those living in poverty, to help ensure that they are accessible, transparent and effective.

Mozambique and Resource Availability

The Special Rapporteur went on mission to Mozambique in December 2003. The mission report includes a chapter on resource availability. This chapter considers the human rights responsibility of international assistance and cooperation in health. It discusses the role of bilateral and multilateral partners, such as the World Bank, in relation to the realization of the right to health in Mozambique.⁷⁰

64. International human rights law recognizes that realizing many aspects of the right to health demand resources. It creates obligations on States to progressively realize the right to health, in accordance with maximum resources available, including resources available from the international community. The four major sources of funds for health financing in Mozambique are the Treasury, bilateral and multilateral funders, employers and households. Under international human rights law, States have primary responsibility to make resources available for the realization of the right to health. Thus, it is incumbent on the Treasury to make maximum resources available for improving health outcomes in the country. The Special Rapporteur also stresses

⁷⁰ E/CN.4/2005/51/Add.2, 4 January 2005 – footnotes have been deleted from the extract.

the responsibility of the international community to provide assistance and cooperation in a manner supportive of Mozambique's efforts to implement its international human rights obligations.

65. National level.

(some deletions)

71. International partners. The realization of the right to health in Mozambique is linked closely to donor assistance. Donors make significant contributions to the health sector as a percentage of overall expenditure, estimated at around 50-60 percent. The PARPA includes an objective of reducing dependence on external financing as a percentage of GDP. While dependence on aid is a serious issue, any aid reduction must not jeopardize health objectives associated with the MDGs and minimum essential levels of the right to health. The Special Rapporteur stresses that the provision of financial and technical assistance by developed states to the Government of Mozambique is not an act of charity. It is an international responsibility arising from obligations of international assistance and cooperation enshrined in binding international human rights treaties, such as CRC and ICESCR. As CESCR has stated, "Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required." The Millennium Declaration and other international conference documents confirm the shared responsibility of all actors for the eradication of extreme poverty, while MDG 8 places particular responsibilities on developed states, including to increase development assistance to countries committed to poverty reduction. Thus, it is incumbent on developed states to provide international assistance and cooperation to the Government of Mozambique. While the bilateral and multilateral partners already make an indispensable contribution to the health sector, it is strongly recommended that they increase their financial and technical assistance to the health sector in Mozambique.
72. In recent years, bilateral and multilateral cooperation partners have developed a more integrated and coordinated approach in relation to their financial and technical assistance in the health sector. For example, the Kaya Kwanga Commitment (Code of Conduct), and the Memorandum of Understanding in respect of the Common Fund for Support to the Health Sector (November 2003), represent significant progress. The Common Fund should help ensure that the Ministry of Health has greater control over allocation of donor resources in accordance with national priorities. However, some major partners, notably USAID and Japan, have declined to become signatories to the Memorandum of Understanding. Thus, the Government of Mozambique has to manage bilateral arrangements in the health sector, as well as the Common Fund, which tends to aggravate its systemic lack of capacity.
73. Accordingly, the Special Rapporteur recommends that all bilateral and multilateral cooperation partners develop an integrated and coordinated approach in the health sector that is as comprehensive, simple and efficient as possible. In particular, he recommends that USAID and Japan join the Common Fund. The need for greater integration and coordination is not confined to the health sector as represented by

- the Ministry of Health and reflected in the Memorandum of Understanding of November 2003. For example, a comprehensive Memorandum of Understanding in relation to the Ministry of Public Works and Housing (whose responsibilities bear closely upon the health of the people of Mozambique) should be negotiated as soon as possible. Bilateral and multilateral partners should ensure that all contributions made under the Common Fund, or other arrangements, are paid promptly according to the agreed schedule.
74. In addition to the contribution made by financial donors, the vital role played by the UN system in Mozambique, including through the provision of technical cooperation and assistance, must be recognized, supported and enhanced.
 75. International financial institutions: The international financial institutions (IFIs) have played a major role in Mozambique since the mid-1980s, through adjustment programmes, investment support and technical assistance. The Special Rapporteur emphasizes that it is incumbent on the IFIs to respect the domestic and international human rights obligations of the Government of Mozambique. They must not pursue policies, or encourage the Government to pursue policies, which are inconsistent with the Government's human rights obligations. The Special Rapporteur encourages the use of impact assessments by IFIs (and other actors) to determine the effect of policies or projects on people living in poverty or other marginalized groups, such as women, children, and people living with HIV/AIDS.
 76. The Special Rapporteur acknowledges the importance of the HIPC and eHIPC initiatives from the point of view of the right to health. Resources freed up under HIPC and eHIPC are allocated to key anti-poverty programmes and, from 1997-2002, debt relief had reportedly contributed 110 billion Mt to the health sector.
 77. As well as setting out national policy priorities for the Government, the PARPA provides a basis for programme support by the IFIs and has become a significant platform for donor and United Nations assistance. While the PARPA is a nationally owned document, it must be endorsed by the IMF and the World Bank if it is to attract programme support from these institutions. The Special Rapporteur recommends that when the IFIs assess and make recommendations on Mozambique's country-owned strategies, including Joint Staff Assessments, they take into consideration Mozambique's national and international human rights obligations.
 78. Despite the significant focus on health in the MDGs, the health sector does not appear to be a priority for the World Bank in its assistance to Mozambique. The World Bank's support of the health sector is very modest, approximately 13 percent of total World Bank support, compared to 14 percent in water and sanitation, 16 percent in education, and 38 percent in transport. The first Poverty Reduction Support Credit (PRSC) disbursed by the World Bank does not include funds for the health sector. The Special Rapporteur is concerned by this limited support and suggests that the World Bank should include a greater focus on assistance to the health sector. He encourages the World Bank to ensure that its second PRSC gives due attention to the health sector, in addition to other sectors vital to poverty reduction, human rights and health, such as water and sanitation.

Uganda, Neglected Diseases, Donors and the International Community

The Special Rapporteur's mission to Uganda in 2005 had a number of distinctive features, one being that it focused on a single issue: neglected diseases, such as river blindness, sleeping sickness and lymphatic filariasis (sometimes called poverty-related or tropical diseases). The report focuses on a number of dimensions to the problem, from research and development to community participation. The following extracts are taken from the sections on 'Donors and the international community' and 'Monitoring and accountability', both of which reflect aspects of IAC-H.⁷¹

70. The primary obligation for implementing the right to health falls upon the State. However, States have the obligation to take steps individually and *through international assistance and cooperation* towards the full realization of various rights, including the right to health. The responsibility of those States that are in a position to assist, to engage in international assistance and cooperation towards the enjoyment of economic, social and cultural rights, is recognized in the Charter of the United Nations, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and elsewhere.
71. Uganda very much depends on aid. In 2001 the amount of official development assistance received was US\$ 782 million. Donors have played a very significant role in Uganda, particularly in the health sector. The Health Policy Statement 2003/2004 estimates that donors contributed 81 per cent of the 2003/2004 development health budget. The donor support is largely managed through a sectorwide approach (SWAp).
72. DFID is the largest bilateral donor. The central focus of its policy is a commitment to nationally agreed targets, including basic health care and universal primary education. It supports SWAp and a number of health initiatives such as the Family Health Projects and the AIDS Service Organization (TASO). The assistance provided by the United States Agency for International Development (USAID) focuses on improving collaboration between TB and HIV VCT services. Other donors assisting the Government in the areas of health, development and poverty reduction include Sweden, Denmark, Germany, Italy, Ireland, UNICEF, the African Development Bank, the World Bank and the European Union. Some donors are project-specific, for example, USAID, Germany and Spain.
73. At the global level, pharmaceutical companies, including Novartis, GSK, Merck, Aventis, Bayer and Bristol Myers Squibb, donate drugs for neglected diseases. Uganda is among the beneficiaries of these donations. Most of the drug donation programmes have nationwide coverage of the endemic areas; however this is subject to problems of insecurity in some districts. While some donations are given for as long as needed, others are time-limited, thereby causing a lack of sustainability of programmes and compounding the funding challenges facing the health sector.
74. A number of Uganda's development partners deserve credit for making considerable financial contributions towards the country's health sector. Also, the management of

⁷¹ E/CN.4/2006/48/Add.2, 19 January 2006 – footnotes have been deleted from the extracts.

donor contributions by way of a sectorwide approach and budget support is to be warmly welcomed. However, despite existing donor support, there remains a wide gap between the cost of a national minimum health-care package in Uganda and the funds that are currently made available for this purpose. For example, according to HSSP, US\$ 28 per person per year is needed to finance Uganda's national minimum health-care package. WHO *Report of the Commission on Macroeconomics and Health* estimates that for a low-income country the minimum financing needed to cover essential health interventions is around US\$ 30 to 40 per person per year. Yet in Uganda the public expenditure - from both the national Government and donors - is only US\$ 9 per person per year, in addition to US\$ 7 per person per year from households and employers. In short, as a United Nations report recently put it: "Uganda is a basket case in chronic underfinancing of the health sector." Thus, the Special Rapporteur recommends that development partners increase their sustainable and predictable contributions to the health sector in Uganda.

75. While recognizing the serious security issues, the Special Rapporteur has formed the view that most donors have paid insufficient attention to the health problems in northern Uganda, where individuals and communities are among the most vulnerable and disadvantaged on the continent.
76. The United Nations is commended for recently strengthening its engagement in the north. To give just one example, WHO has recently opened a sub-office in Gulu, and OHCHR has set up a human rights presence to undertake human rights monitoring and training, and to work on a protection strategy in cooperation with the National Human Rights Commission and the United Nations Country Team. However, on the whole, it appears to the Special Rapporteur that the United Nations was slow to recognize the severity of the humanitarian crisis in northern Uganda. For many years the acute needs of the local population did not receive the international attention and support it desperately needed. To this day, adequate and well-coordinated international assistance does not reach the people of northern Uganda. Thus, as a matter of urgency, the international community and all donors should devote more attention to, and invest more health and other resources in, northern Uganda.
77. Budget ceilings: In recent years, there has been much controversy in Uganda about macroeconomic policies, the application of inflexible ceilings to the health budget, and the absorption of foreign funds that are available to the health sector.
78. From the perspective of the right to health, the following points must be kept in mind when considering this important issue. First, the Government is obliged to take into account its binding national and international right-to-health obligations to all those within its jurisdiction.
79. Second, if the Government declines health resources from overseas, prima facie this would be inconsistent with its international obligation to use the maximum resources available for the implementation of the right to health. However, if there were objective and rational grounds for declining such foreign funds, the Government would not be in breach of its international right-to-health obligations. In such a situation, the Government has the burden of proving that the resources have been declined on objective and rational grounds that are consistent with all of its national

- and international human rights obligations. When evaluating the grounds for any decision to decline foreign funds, special regard must be given to the impact of the decision on Uganda's most vulnerable individuals and communities, including those living in poverty.
80. Third, development partners may not apply any pressure on the Government to impose inflexible budget ceilings that would or may have the effect of restricting the flow of available funds into the health sector.
 81. "A global epidemic of global initiatives": Uganda benefits from a large number of global initiatives for different diseases, such as the Global Alliance for Leprosy Elimination, the Global Alliance for the Elimination of Lymphatic Filariasis, and the National Onchocerciasis Control Programme. These global programmes translate into a range of national initiatives. Although these initiatives bring significant benefits, they also place a very considerable administrative burden on the Ugandan authorities. As argued elsewhere in the present report, much greater integration among interventions and initiatives is needed at the district, national and international levels, so as to make the most effective use of scarce resources (see section on "An integrated health system responsive to local priorities"). Donors and the international community have a particular responsibility to better coordinate their activities, working in close cooperation with the Ministry of Health.
 82. WHO: The Special Rapporteur urges WHO to more proactively assume a coordinating role among the myriad health partners working throughout Uganda. For example, WHO could provide a regular forum for information exchange and discussion across a very wide range of health actors. WHO is also encouraged to collect more – and better quality - health information from the local level, with a view to enhancing local, national and international policy-making. Further, it is urged to invest more resources in neglected diseases and neglected populations.
 83. Research and development: Donors and the international community should give a higher priority to health research and development in Uganda. They should actively seek new funding mechanisms for research and development in relation to neglected diseases. They may need to increase direct funding for public research and enhance private sector incentives, such as tax credits. Intellectual property regimes must not be allowed to constrain access to essential medicines. So far as necessary, new intellectual property frameworks for neglected diseases and essential medicines should be explored. The fruits of research and development in relation to neglected diseases must be translated into specific drugs, vaccines and diagnostics that are accessible to the afflicted populations. Donors and the international community should help Uganda enhance its economic and technological capacity so it can determine its own research and development agenda and priorities in relation to neglected diseases.
 84. Pharmaceutical companies: A number of pharmaceutical companies deserve credit for initiatives that enhance access to essential medicines and medical care. However, they should be encouraged to improve their coordination amongst themselves, as well as with other actors working in the health sector. While on mission, the Special Rapporteur was informed that the pharmaceutical companies were invisible outside the major urban areas, other than when organizing seminars to promote their

products. Accordingly, they should be encouraged to regularly visit disadvantaged communities, urban and rural, including the internally displaced persons camps, to learn at first hand about the health realities of those living in poverty. Regular visits of this type should be reported to the companies' national and international headquarters with a view to informing policies and finding ways in which the companies can assist in the implementation of the right to health for all.

(some deletions)

Monitoring and accountability

(some deletions)

91. A right-to-health approach to neglected diseases and populations requires accessible, transparent and effective human rights mechanisms of monitoring and accountability. The existing mechanisms need to be enhanced. It is recommended that, for an experimental period of three years, the Uganda Human Rights Commission establish a right-to-health unit that is responsible for monitoring those policies, programmes and projects relating to neglected diseases. For example, relying on existing data, the unit should track the incidence of neglected diseases and the initiatives taken to address them.
92. Further, the right-to-health unit should go beyond monitoring and hold all actors to account in relation to neglected diseases and the right to health. For example, adopting an evidence-based approach, the unit would endeavour to assess which initiatives are working and which are not - and if not, why not. In its monitoring and accountability functions, the unit should consider the acts and omissions of all actors bearing on neglected diseases in Uganda. Significantly, the unit should monitor and hold to account national and international actors in the public and private sectors.
93. The unit should consist of a health professional and a human rights expert. They should submit a public annual report to Parliament which would indicate where successful initiatives have led to positive health outcomes, as well as highlight where there are concerns. Whenever possible, realistic and practical recommendations should be identified for all actors. At all times, the unit's yardstick should be the national and international right-to-health standards to which the Government of Uganda has agreed to be bound.

Countries Acceding to the World Trade Organisation

In several places, the Special Rapporteur's report on the World Trade Organisation (WTO) raises the issue of international assistance and cooperation in health. One is in relation to countries seeking to accede to the WTO. Some of the relevant extracts are set out in the following paragraphs.⁷²

66. A question of serious concern relates to the level of commitments to trade liberalization undertaken by acceding countries to WTO. As part of the process of accession, would-be WTO members enter into negotiations with existing WTO

⁷² E/CN.4/2004/49/Add.1, 1 March 2004 – several footnotes have been deleted from the extract and one has been added.

- members to discuss their national trade policies and the level of commitments to trade liberalization they will undertake before they become members of the organization. Interlocutors referred the Special Rapporteur to a recent publication of the Commonwealth Secretariat which concluded that “the process of accession to the WTO is fundamentally flawed”.
67. First, acceding countries have sometimes accepted demands that are not required under WTO Agreements - known as “WTO plus” - or have foregone benefits or rights included in WTO Agreements - known as “WTO minus”. WHO regards “TRIPS plus” as “a non-technical term which refers to efforts to extend patent life beyond the 20-year TRIPS minimum; limit compulsory licensing in ways not required by TRIPS; and limit exceptions which facilitate prompt introduction of generics”. The term “TRIPS plus” is also used to refer to situations where countries implement TRIPS-consistent legislation before they are obliged to do so. The use of trade pressure to impose “TRIPS plus”-style intellectual property legislation could lead member States to implement intellectual property standards that do not take into account the safeguards and flexibilities included under the TRIPS Agreement, which in turn could constrain States from implementing intellectual property systems that provide adequate policy space for the promotion of the right to health.
68. Second, the process of accession negotiations sometimes leads to demands from stronger WTO members for acceding countries to undertake greater commitments than those made by WTO members of a similar developmental status. The Commonwealth Secretariat study compared commitments to the liberalization of trade in services under GATS made by acceding countries as opposed to those of existing WTO members, and concluded that “at each level of services sectoral classification, the commitments made by acceding countries were far larger than those made by WTO Members”. Third, the Special Rapporteur is concerned about the situation of recently acceding countries that are under pressure to undertake further commitments to trade liberalization in the current round of trade negotiations launched at Doha while they are still implementing and adjusting to the commitments they undertook during the accession process.
69. The Special Rapporteur reiterates his opinion that international human rights law is neither for nor against any particular trade rule or policy, subject to two conditions.⁷³ However, he is concerned that pressure in trade negotiations, particularly when exercised by stronger trading partners over smaller acceding countries, might lead to unsustainable commitments to trade liberalization that, in practice, diminish States’ capacity to realize the right to health. Powerful States have a human rights responsibility of international assistance and cooperation in relation to the right to health which means, inter alia, that they should respect the obligation of an acceding State to realize the right to health of individuals in its jurisdiction. In other words, during accession negotiations, the various human rights responsibilities of all parties should be kept in mind. At root, human rights remain a check against the possible misuse of power.

⁷³ The two conditions are explained in paragraph 11 of the WTO report. In brief, first, the rule or policy must, in practice, actually enhance enjoyment of human rights, including for the disadvantaged and marginal; second, the process by which the rule or policy is formulated, implemented and monitored must be consistent with all human rights and democratic principles.

United States-Peru Trade Agreement

One of the most controversial contemporary political issues in Peru – including in this month’s presidential election – concerns the US-Peru trade agreement which has been negotiated over the last couple of years. In his mission report of 2005, the Special Rapporteur linked these negotiations to the domestic and international human rights obligations of Peru, as well as the international human rights responsibilities of USA. Specifically, the report relies upon Peru’s obligations arising from the right to health, and the responsibilities of the US regarding international assistance and cooperation in health. A few extracts from the report are set out below.⁷⁴ The argument was extended in press releases of July 2004 and July 2005.

47. At the time of the Special Rapporteur’s mission, the Government of Peru was engaged in negotiations towards a bilateral trade agreement with the United States. While the agreement may cover a wide range of issues, for the purposes of the present report the Special Rapporteur focuses on the potential impact of the trade agreement on access to essential medicines in Peru.
48. The Special Rapporteur is concerned that the bilateral trade agreement may result in “WTO-plus” restrictions, including new patent and registration regulations that impede access to essential medicines for those living in poverty. In the past, Peruvian legislation did not allow for pharmaceutical patents. The Special Rapporteur is concerned that the agreement might allow for the grant of a five-year patent-like monopoly for drugs that are not patented by the original manufacturer. He is also concerned that the agreement might allow companies to apply for a new 20-year patent for each “new use” of a product, and that it might propose the establishment of a national drug regulatory body to monitor the enforcement of drug patents, including by delaying or blocking generic medicines. If these provisions were introduced and implemented, they would significantly impede access to affordable essential medicines for some individuals and groups, including antiretrovirals for people living with HIV/AIDS. Such provisions would undermine the consensus reached at the WTO on the need to balance the protection of intellectual property and the protection of public health.
49. The Special Rapporteur stresses the human rights responsibility of countries to make use of the safeguards available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health - such as compulsory licences - to protect public health and promote access to medicines. He recalls that TRIPS and the Doha Declaration allow countries to protect public health. Thus, the conclusion of bilateral trade agreements must not result in a restriction on Peru’s ability to use the public health safeguards enshrined in TRIPS and the Doha Declaration (see E/CN.4/2004/49/Add.1).
50. The Special Rapporteur urges Peru to take its human rights obligations into account when negotiating bilateral trade agreements. He suggests that before any trade agreement is finalized assessments identify the likely impact of the agreement on the

⁷⁴ E/CN.4/2005/51/Add.3, 4 February 2005 – footnotes have been deleted from the extract.

enjoyment of the right to health, including access to essential medicines and health care, especially of those living in poverty. All stages of the negotiations must be open, transparent and subject to public scrutiny.

51. In accordance with its human rights responsibility of international cooperation, the United States should not apply pressure on Peru to enter into commitments that either are inconsistent with Peru's constitutional and international human rights obligations, or by their nature are "WTO-plus".

Mental Disability

The Special Rapporteur's report on mental disability also raises the issue of international assistance and cooperation in health.⁷⁵

63. States should respect the right to health in other countries, ensure that their actions as members of international organizations take due account of the right to health, and pay particular attention to helping other States give effect to minimum essential levels of health.
64. Mental health care and support services are not a priority health area for donors. Where donors have provided financial assistance, this has sometimes supported inappropriate programmes, such as rebuilding a damaged psychiatric institution that was first constructed many years ago on the basis of conceptions of mental disability that are now discredited. By funding such a reconstruction, the donor inadvertently prolongs, for many years, seriously inappropriate approaches to mental disability. It is also unacceptable for a donor to fund a programme that moves a psychiatric institution to an isolated location, making it impossible for the users to sustain or develop their links with the community. If a donor wishes to assist children with intellectual disabilities, it might wish to fund community-based services to support children and their parents, enabling the children to remain at home, instead of funding new facilities in a remote institution that the parents can only afford to visit once a month, if at all.
65. The Special Rapporteur urges donors to consider more - and better-quality - support in the area of mental disability. In accordance with their responsibility of international assistance and cooperation, donors should support a range of measures such as: supporting the development of appropriate community-based care and support services; supporting advocacy by persons with mental disabilities, their families and representative organizations; and providing policy and technical expertise. Donors should ensure that all their programmes promote equality and non-discrimination for persons with mental disabilities. Some agencies are already giving attention to these issues. For example, the United States Agency for International Development (USAID) now requires all applicants for funding to demonstrate how their programmes would be accessible to people with disabilities.
66. A further aspect of international assistance and cooperation is the role played by international agencies in providing technical support. On this point, the Special

⁷⁵ E/CN.4/2005/51, 11 February 2005 – footnotes have been deleted from the extract.

Rapporteur emphasizes his support for the excellent technical support being carried out by organizations such as WHO and PAHO, as well as their publication of a range of excellent handbooks and guides on legislation and policy-making, including human rights dimensions.

The Skills Drain: The Migration of Health Professionals

One of the Special Rapporteur's reports provides a human rights analysis of the migration of health professionals from South to North (the 'skills drain'). This analysis encompasses several human rights, but it gives particular attention to the right to health. Several elements of the right to health are brought to bear upon the skills drain, including the responsibility of international assistance and cooperation. The following extracts relate to the human rights responsibility of international assistance and cooperation in the context of the skills drain.⁷⁶

International assistance and cooperation

59. In addition to obligations at the domestic level, States have a responsibility deriving from, inter alia, article 2, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights and article 4 of the Convention on the Rights of the Child to take measures of international assistance and cooperation towards the realization of economic, social and cultural rights, including the right to health. This responsibility, which is particularly incumbent on developed States, also arises in the context of commitments made at recent world conferences, including the Millennium Summit, and to Millennium Development Goal 8 (see A/59/422).
60. Like other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, as the next paragraphs illustrate, international assistance and cooperation is not simply a matter of developed countries making funds available to developing countries. In the context of the right to health and the skills drain, the human rights responsibility of international assistance and cooperation encompasses a number of dimensions, including the following.
61. First, developed countries should respect the right to health in developing countries. For example, developed countries should ensure that their human resource policies do not jeopardize the right to health in developing countries. If a developed country actively recruits health professionals from a developing country that is suffering from a shortage of health professionals in such a manner that the recruitment reduces the developing country's capacity to fulfil the right to health obligations that it owes its citizens, the developed country is prima facie in breach of its human rights responsibility of international assistance and cooperation in the context of the right to health. Some countries have developed policies that reflect this principle.
62. Second, States should take all reasonable measures to prevent third parties from jeopardizing the enjoyment of the right to health in other countries, so

⁷⁶ A/60/348, 12 September 2005 – footnotes have been deleted from the extracts.

- far as they are able to influence such third parties by way of legal or political means. For example, States should regulate private recruitment agencies that operate internationally with a view to ensuring that they do not recruit in a manner that reduces a developing country's capacity to fulfil the right to health obligations that it owes to those within its jurisdiction.
63. Third, States should ensure that the right to health is given due attention when drafting and implementing international agreements, for example, when negotiating their scheduled commitments under GATS mode 4 (which concern, inter alia, health professionals temporarily entering another country to provide a health service). In a previous report, the Special Rapporteur observes that if increased trade in services were to lead to substandard health facilities, goods and services, this would prima facie be inconsistent with the right to health (E/CN.4/2004/49/Add.1, para. 49). If a State chooses to engage in trade liberalization, including in relation to services, then it should select the form, pacing and sequencing of liberalization that is most conducive to the progressive realization of the right to health for all, including those living in poverty and other disadvantaged groups (ibid., paras. 30 and 46-56). The form, pacing and sequencing of liberalization should be selected on the basis of right to health impact assessments. In this way, a draft mode 4 commitment could be revised, if necessary, so as to ensure that it will not have a negative impact on the right to health of all. Consistent with their responsibility of international assistance and cooperation, developed States should not apply undue pressure on developing countries to make mode 4 commitments that are inconsistent with developing countries' obligations arising from the right to health.
 64. Fourth, depending on resource availability, States should provide aid to developing countries so as to facilitate access to essential health facilities, goods and services, especially for those living in poverty and other disadvantaged groups. Aid policies should include support for human resources in the health sector.
 65. However, the central point is that it is disingenuous for developed countries to provide overseas development assistance, debt relief and other forms of international assistance and cooperation to developing countries, while simultaneously hiring health professionals who have been trained at the expense of, and are desperately needed in, the developing countries of origin. What is the point of giving with one hand and taking with the other?

Accountability

66. International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window dressing. Accordingly, a human rights — or right to health — approach emphasizes obligations and requires that all duty holders be held to account for their conduct.
67. All too often, "accountability" is used to mean blame and punishment. But this narrow understanding of the term is much too limited. A right to health

- accountability mechanism establishes which health policies and institutions are working and which are not, and why, with the objective of improving the realization of the right to health. Such an accountability device has to be effective, transparent and accessible.
68. In the context of the skills drain, national and international accountability mechanisms are needed in relation to the discharge of the various human rights obligations of the various actors. For example, national mechanisms should monitor the human rights of health professionals in their countries of origin. In countries of destination, national mechanisms should monitor the human rights of health professionals, including migrants. Also, international accountability mechanisms, such as treaty bodies, should consider the human rights of health professionals in countries of origin and destination.
 69. However, these national and international accountability mechanisms should not only encompass the human rights of health professionals, they should also consider the impact of the skills drain on relevant health systems. In other words, the mechanisms should consider the impact of the skills drain on the enjoyment of the right to health of individuals and communities in both countries of origin and destination. It is necessary to develop indicators and benchmarks to monitor the right to health dimensions of the skills drain, including the responsibilities of countries of origin and destination (see A/58/427 and A/59/422 for the Special Rapporteur's approach to this question).
 70. Here, an important point demands emphasis. There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.
 71. There is no doubt that national and international accountability mechanisms in relation to developed countries' responsibility of international assistance and cooperation remain weak. For example, there are few (if any) national or international mechanisms that give adequate attention to the impact of a developed country's policies on the skills drain and its effect upon the enjoyment of the right to health in countries of origin. This state of affairs is unacceptable because human rights require effective, transparent and accessible accountability mechanisms in relation to the human rights responsibilities of all actors.
 72. In the conclusion to this chapter the Special Rapporteur makes a modest proposal — a national office to monitor international cooperation in health — to address this lacuna in the promotion and protection of the right to health.
(some deletions)

Conclusion

75. As already mentioned, there are numerous policy responses to the negative impacts of the skills drain, including strengthening health systems in countries of origin, and destination countries strengthening their own domestically

trained human resource base. Unfortunately, lack of space does not permit the Special Rapporteur to examine them in detail in this chapter.

(some deletions)

76. *Strengthen health systems in countries of origin.* Consistent with the right to health, one vital policy response to the skills drain is to strengthen health systems in developing countries of origin. A higher priority should be given to human resources in the health sectors of countries of origin, including enhanced terms, conditions, professional development, planning, management and incentives to work in the rural areas. More health professionals are needed, requiring more training resources. Integrated district health systems must be strengthened, their infrastructure upgraded and the role of community health workers enlarged. Governance, including public participation, and effectiveness in the health sector demand serious attention. If the health systems of developing countries of origin are to be strengthened, donors and development partners have an indispensable role to play, as anticipated by numerous international commitments, including the human rights responsibility of international assistance and cooperation.

(some deletions)

82. *Compensation.* The migration of health professionals from developing countries where there are staff shortages to developed countries imposes substantial economic and social costs on countries of origin, while saving developed countries' health services significant training costs. The economic name for this process is a "subsidy". The subsidy is perverse because it flows from poor to rich countries, worsening existing global inequalities in health care and protection. This process has been called, inter alia, a "perverse subsidy", an "unjust subsidy" and "reverse foreign aid".
83. As well as being ethically indefensible, this flow of resources from poor to rich is inconsistent with developed countries' human rights responsibility of international assistance and cooperation, as well as other international commitments, including the Millennium Declaration and Goal 8 (a global partnership for development) (see paras. 59-65). There is a compelling case that this perverse subsidy should be redressed by the payment of compensation, restitution or reparation to those developing countries of origin where the skills drain reduces their capacity to fulfil the right to health obligations that they owe their citizens.
84. The call for compensation raises a number of objections and challenges that deserve careful attention. With genuine political commitment, however, they are unlikely to prove insurmountable. Compensation could be paid into a restitution fund that is properly managed and used for specific health purposes agreed by all the parties, such as support for health staff remaining in or returning to the country in question.
85. The Special Rapporteur strongly recommends that when the skills drain amounts to a perverse subsidy the policy response of compensation should be given serious and sympathetic consideration.

86. *A national office to monitor international cooperation on health.* Each developed country should establish an independent national office to monitor the impact of the Government's policies on the enjoyment of the right to health in developing countries. Along the lines of an ombudsman, the office should report annually to the national legislature. It should have the power to make investigations, conduct inquiries and monitor the Government's international commitments and pledges on health matters. Responsibility for these international health commitments is often spread across various ministries — health, finance, foreign affairs, trade, international development and so on — thereby complicating both coordination and accountability.
87. One of the health issues that the office should monitor is the skills drain. In many countries, there is a dearth of reliable data on the skills drain, so one of the office's tasks would be to ensure that the Government collects the necessary data. What is the extent of the skills drain in the country in question? Which national policies are impacting upon the skills drain? What is the impact of the skills drain, especially in the countries of origin? How might national policies be revised to make them consistent with the Government's human rights responsibilities, including international assistance and cooperation for health? An ombudsman-style office that asks these sorts of questions would complement and strengthen existing accountability mechanisms, such as parliamentary subcommittees.
88. The office might also serve as a watchdog for national codes of conduct on ethical recruitment, such as the one adopted by the United Kingdom National Health Service, as well as national implementation of comparable international codes, such as the Code of Practice for the International Recruitment of Health Workers adopted by the Commonwealth Secretariat in 2003.

Indicators and Benchmarks for Measuring IAC-H

Serious attempts are being made by a number of actors to devise indicators and benchmarks that can help to measure the progressive realisation of the right to health. For his part, the Special Rapporteur has written three reports on this difficult issue. For present purposes, the important point is that indicators and benchmarks are needed to encompass the responsibilities of States at both the national and international levels. In other words, indicators and benchmarks are needed to measure donors' international assistance and cooperation in health. In a preliminary fashion, this point was made in the Special Rapporteur's first report on indicators that is extracted below.⁷⁷

30. The main focus of international human rights law is directed to the acts and omissions of states within their own jurisdictions. Naturally, therefore, discussions about human rights indicators tend to have the same orientation. Indeed, the illustrative indicators mentioned in the preceding paragraphs focus on the national level.
31. However, as the Special Rapporteur noted in his preliminary report, international human rights also place responsibilities on states in relation to their conduct beyond

⁷⁷ A/58/427, 10 October 2003. Footnotes have been deleted from the extract.

their own jurisdictions - consider the references to international assistance and cooperation, and similar formulations, in the Universal Declaration of Human Rights, as well as in binding human rights treaties, such as ICESCR and the Convention on the Rights of the Child. Moreover, the outcomes of recent world conferences include passages that resonate with the international assistance and cooperation provisions of international human rights law. In the Millennium Declaration, for example, 147 Heads of State and Government - 191 nations in total - recognise that: “in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level” (para. 2) The Millennium Declaration repeatedly affirms the twin principles of shared responsibility and global equity, principles that also animate the human rights concept of international assistance of cooperation.

32. In this context, the Special Rapporteur makes two general observations about the human rights concept of international assistance and cooperation. First, international assistance and cooperation should not be understood as encompassing only financial and technical assistance: it also includes a responsibility to work actively towards equitable multilateral trading, investment and financial systems that are conducive to the reduction and elimination of poverty. Second, while lawyers may debate the legal nature and scope of international assistance and cooperation under international human rights law, nobody can seriously dispute that states have, to one degree or another, international human rights responsibilities that extend beyond their own borders.
33. In these circumstances, human rights indicators are needed to monitor the discharge of a state's human rights responsibilities that extend beyond its borders. The international community has already begun to identify indicators that monitor states' responsibilities beyond their own borders. For example, a number of indicators have been identified in relation to Millennium Development Goal 8, one of them being the amount of a donor's overseas development assistance as a percentage of its gross national product. In 2001, the General Assembly Special Session on HIV/AIDS adopted the Declaration of Commitment on HIV/AIDS and, in the following year, the Programme Coordinating Board of UNAIDS approved a set of core indicators for implementation of the Declaration of Commitment. Five of these core indicators relate to the global level. One indicator is the amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition; another is the percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes. The Special Rapporteur is not arguing here that these are human rights indicators, but that they provide a precedent for the formulation of human rights indicators at the international level.
34. The crucial point is that any attempt to identify right to health indicators must encompass the responsibilities of states at both the national and international levels. For his part, the Special Rapporteur proposes to identify, in his forthcoming work, possible right to health indicators at both levels.

In two subsequent reports, the Special Rapporteur has given further attention to the form that donors' LAC-H indicators might take.⁷⁸ For example, this year he looked at sexual and reproductive health rights and identified a large number of possible indicators at the national level, as well as a few indicators for donors' LAC-H.⁷⁹ These donors' LAC-H indicators include:

- *Does the State's overseas development policy include specific provisions to promote and protect sexual and reproductive health rights?*
- *What is the percentage of overseas development assistance directed to sexual and reproductive health?*
- *Do the State's reports to the human rights treaty-based bodies include a detailed account of the international assistance and cooperation it is providing, including in relation to sexual and reproductive health?*
- *Does the State provide a country-specific annual report of its international assistance and cooperation, including in relation to sexual and reproductive health: (a) to the government of the recipient country? (b) to the public of the recipient country?*

Clearly, these are very preliminary, experimental steps. For the future, a major challenge is to devise appropriate indicators and benchmarks to help to measure donors' discharge of their human rights responsibilities of LAC-H.

⁷⁸ A/59/422, 8 October 2004 and E/CN.4/2006/48, 3 March 2006.

⁷⁹ E/CN.4/2006/48, 3 March 2006 – for donors' indicators see in particular page 28.

CONCLUSION

This paper has made the case that international assistance and cooperation for the highest attainable standard of health is both a right and obligation under ICESCR. As well as its explicit recognition as an obligation in ICESCR, CESCR, UN Special Rapporteurs and other commentators have all emphasised that IAC is an obligation. In this paper we argue that IAC should also be considered as a normative element of each right in ICESCR, a position supported both by the UDHR and the analysis of some commentators.

The nature and scope of IAC-H, and its applications in various policy contexts, has been given some clarity by the work of CESCR and the UN Special Rapporteur on the right to the highest attainable standard of health. For example, the work of CESCR confirms that it is possible to confidently assert that IAC gives rise to obligations on States to respect, protect and fulfil the right to health in other countries. And that IAC is particularly closely related to the duty on States to give effect to core obligations under the Covenant. The Special Rapporteur on the right to the highest attainable standard of health has begun to apply the general framework of norms and obligations for IAC-H in particular contexts. His work begins to clarify the relationship of IAC-H to issues and policies including: poverty reduction strategies; the skills drain; trade negotiations involving intellectual property right protections; indicators; aid modalities; and the conduct of donors including their relationship with aid recipients.

While some progress has been made in understanding the nature of the obligation and right of IAC, as with many human rights there are important issues which are still less clear and require further discussion. For example, what, if anything, would be the obligation of a donor if a recipient state lacked will and failed to give effect to the right to health of a particular population group, such as women or an indigenous population? A further issue which demands further attention is the relationship of donor conditionality to IAC-H. If a donor withdraws or reduces its development assistance including in the area of health because a recipient State has failed to meet certain legitimate conditions (e.g. minimise corruption), would this be contrary to that donor's obligations under ICESCR? Another question is if a donor gives its aid through direct budget support, but national policies which it is supporting do not contribute to (or violate) the right to health, what implications does this have for IAC? And a question which donors may wish to ask is what are its priority interventions with respect to IAC-H? These are complex policy issues which demand further attention and discussion.

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