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Patricia C. Kuszler

University of Washington School of Law

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Patricia C. Kuszler, *Global Health and Human Rights Imperative*, 2 *ASIAN J. WTO & INT'L HEALTH L. & POL'Y* 99 (2007), <https://digitalcommons.law.uw.edu/faculty-articles/381>

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GLOBAL HEALTH AND THE HUMAN RIGHTS IMPERATIVE

*Patricia C. Kuszler**

ABSTRACT

Open any magazine, click on a television news channel, or surf the net and you are likely to find global health highlighted as one of the foremost challenges of new millennium. First, this article will consider the meaning and measures of global health and detail the path to improved health and development prescribed by the United Nations Millennium Development Goals. Second, it will trace the development of international human rights law as it relates to health. Third, it demonstrate how human rights and health, long traversing parallel routes, are in fact converging in the 21st Century quest for global health – a quest that is simultaneously being driven by evolving international rights and norms related to trade, labor, the environment and human security. The article will conclude that global health and human rights are products of new international norms of governance borne of our interdependence and ongoing multilateral collaboration.

KEYWORDS: *global health; human rights; international law*

* MD, JD, University of Washington School of Law.

Open any magazine,¹ click on a television news channel,² or surf the net³ and you will find global health highlighted as one of the foremost challenges of the new millennium. During the twentieth century, health was considered in a relative fashion by individual nation states or regions using a variety of metrics. Life expectancy, infant and child mortality rates, and access to high-tech procedures were among the typically cited measures, either with pride or derision. Industrialized nations, like the United States, looked at health status through the lens of a highly developed medical technology. Improved health in such countries was a product of access to services, pharmaceutical therapies, and technologies to correct physical pathology in the human body. By such measures, developing or poverty-stricken nations were far behind in achieving population health and there was little hope that, even with enhanced aid, significant improvement in health could be achieved and sustained. Many of these countries still suffered from measles, polio and diarrheal disease – epidemic diseases that had been conquered by the industrialized developed nations by the mid-twentieth century.

First, this article will consider the meaning and measures of global health, detailing the path to improved health and development prescribed by the United Nations Millennium Development Goals. Second, it will trace the development of international human rights law as it relates to health. Third, it will demonstrate how human rights and health, long traversing parallel routes, are in fact converging in the twenty-first century quest for global health – a quest that is also being driven by evolving international rights and norms related to trade, labor, the environment and human security. The article will conclude that global health and human rights are simultaneously precursors and products of evolving international norms of governance that are borne of our interdependence and require ongoing multilateral collaboration.

I. GLOBAL HEALTH AND THE NEW MILLENNIUM: DEVELOPMENT AND DISPARITIES

Global health status at the dawn of the new millennium evidenced dramatic improvements coupled with disturbing disparities. Overall life

¹ See e.g. NEWSWEEK MAGAZINE, May 15, 2006, a series of articles examining the HIV/AIDS Pandemic on 25th Anniversary of First AIDS Diagnosis.

² See e.g. Rx for Survival: A Global Health Challenge, a six-part series aired on the Public Broadcast System (PBS), <http://www.pbs.org/wgbh/rxforsurvival/series/about/series.html> (last visited Feb 13, 2007).

³ See e.g. Global Health Council - A Voice for Global Health, <http://www.globalhealth.org/> (last visited Feb 13, 2007).

expectancy increased by nearly 20 years from 1950 to 2002.⁴ Developed countries like the United States experienced an average gain in life expectancy of nine years, while developing countries, even those with high mortality rates, experienced even more substantial gains.⁵ However absolute life expectancy statistics reveal tremendous disparity. In 2002, the life expectancy of a newborn female in a developed country was 78 years, but the life expectancy of a newborn male in sub-Saharan Africa was less than 46.⁶ In fact, life expectancies in the high mortality, developing countries of Africa peaked in the late twentieth century and actually have decreased as a result of the AIDS epidemic.⁷

Child mortality is the prime driver for low life expectancy in developing countries. Of the 20 countries with the highest child mortality, 19 of them are in Africa.⁸ In several sub-Saharan countries, HIV/AIDS has completely ablated the improved child survival achieved in the mid twentieth century.⁹ Despite the dismal situation in Africa, child mortality has declined in 169 countries, 112 of which are classified as developing countries.¹⁰ This decline in mortality is the result of improvements in care and treatment of diarrheal disease and immunization against infectious diseases and tetanus.¹¹

Adult mortality rates demonstrate a similar pattern. While overall adult mortality has declined dramatically, this has leveled off over recent years and in some developing countries mortality rates are actually increasing.¹² The leveling phenomenon is the result of already achieved improvements in childhood health, but virtually no improvement in mortality from non-communicable, chronic diseases such as cardiovascular disease, cancer and neuropsychiatric disorders.¹³ The growing role of non-communicable disease in adult mortality is marked in developed industrialized countries, where it accounts for 80% of adult deaths.¹⁴ However, it also compounds the life expectancy gap in developing countries. Such maladies have become an increasing factor in adult mortality in these countries, accounting for 50% of the adult disease burden. Developing countries,

⁴ WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT 2003 — SHAPING THE FUTURE 3 (2003) [hereinafter WHO 2003].

⁵ *Id.* at 3. Low mortality developing countries (e.g. China) gained 26 years in life expectancy during this period, while high mortality developing countries (e.g. Africa, Latin America) added only 17 years to their average life expectancy.

⁶ *Id.* at 4.

⁷ *Id.* at 16.

⁸ *Id.* at 8.

⁹ *Id.* at 10.

¹⁰ *Id.* at 12.

¹¹ *Id.* at 12-13.

¹² *Id.* at 13.

¹³ *Id.* at 13.

¹⁴ *Id.* at 14.

especially those in the grip of HIV/AIDS, are beset with simultaneously increasing incidence of these non-communicable disease threats to their adult populations.¹⁵

The net result is increasing, rather than decreasing, adult mortality.

Although HIV/AIDS has decimated gains in health and life expectancy in many of the developing countries of Africa, it has also altered the playing field and stimulated new examination of health and its determinants.¹⁶ Because of HIV's rapid spread across low, middle and high income countries, the folly of considering health from a local perspective became obvious.¹⁷ Emerging and re-emerging infectious diseases recognize no borders.¹⁸ Early on, it was patently clear that this new infectious disease had a global dimension crossing numerous geographic, social and cultural boundaries.¹⁹ The lesson was reinforced in 2003 when the SARS epidemic circled the globe with frightening speed.²⁰ Moreover, the easy belief that health could be viewed simply as a product of access to health services was eclipsed by the growing realization that health is the product of a complex set of social and economic determinants.²¹ This new awareness sparked global communication and international collaboration leading to the United Nations Millennium Declaration in 2000.

The Millennium Declaration speaks to the growing understanding of collective responsibility in the age of globalization.²² This understanding has become more pronounced in the six years following adoption of the Declaration:

Six years ago, leaders from every country agreed on a vision for the future – a world with less poverty, hunger and disease, greater survival prospects for mothers and their infants, better educated children, equal opportunities for women, and a healthier environment; a world in which developed and developing countries worked in partnership for the betterment of all. This vision took the shape of eight Millennium Goals,

¹⁵ *Id.* at 13.

¹⁶ See Allyn L. Taylor, *Governing the Globalization of Public Health*, 32 J. L. MED. & ETHICS 500, 500 (2004).

¹⁷ See *id.* at 500; see also Sofia Gruskin & Daniel Tarantola, *Health and Human Rights*, in OXFORD TEXTBOOK OF PUBLIC HEALTH 311 (Roger Detels et al. eds., 4th ed. 2002); David P. Fidler, *Caught Between Paradise and Power: Public Health, Pathogenic Threats and the Axis of Illness*, 35 MCGEORGE L. REV. 45, 73 (2004).

¹⁸ Laurie Z. Asher, *Confronting Disease in a Global Arena*, 9 CARDOZO J. INT'L & COMP. L. 135, 138 (2001).

¹⁹ Allyn L. Taylor, *supra* note 16, at 500; David P. Fidler, *supra* note 17, at 77.

²⁰ See Allyn L. Taylor, *supra* note 16, at 500-01.

²¹ See generally Center for Economic and Social Rights, *A New Approach to Monitoring and Advocating for Economic and Social Rights*, <http://cesr.org> (last visited Feb 13, 2007).

²² United Nations Millennium Declaration, G.A. Res. A/55/L.2 (2000) [hereinafter Millennium Declaration].

which are providing countries around the world a framework for development and time-bound targets by which progress can be measured.²³

The Millennium Development Goals have defined targets and measurable indicators, designed to improve global health, well-being and security.²⁴ Moreover they seek to hold the world's countries accountable for working together to advance these goals and achieve these targets.²⁵

Perhaps the most daunting of the Goals is the first. It pledges to eradicate poverty and improve the health and welfare of the world's poorest populations by 2015.²⁶

This first Millennium Goal is particularly critical to improving child health. Regardless of the state of a country's economic development, children are at a higher risk of death if they are poor.²⁷ The child mortality gap between developing countries with improved economies and fully developed, industrialized countries is progressively narrowing.²⁸ Meanwhile, poverty-stricken developing countries lag further and further behind their more economically stable neighbors in the developing world.²⁹ For example, an infant born in Sierra Leone is three and a half times more likely to die before age five than an infant born in India;³⁰ If that infant from Sierra Leone survives, he will die 43 years before an infant born in Japan in the same year.³¹ During the last decade, progress in conquering poverty has been slow, but demonstrable. While 28% of the developing world's population lived in extreme poverty in 1990, this number had decreased to 19% in 2002.³² Much of this decline in poverty resulted from significantly improved economic conditions in Asia. In sub-Saharan Africa, the number of people living in extreme poverty and hunger actually increased.³³ The net result, and concern, is that the pace of eradicating poverty must increase dramatically to meet the 2015 target.

Notably, three of the other Millennium Goals directly address health and virtually all of them address social and/or economic determinants of

²³ United Nations, *The Millennium Development Goals Report 2006*, 3 (2006) [hereinafter *MDG Report 2006*].

²⁴ See Millennium Development Goals, <http://www.who.int/mdg/en/> (last visited Feb 13, 2007).

²⁵ See *MDG Report 2006*, *supra* note 23, at 3.

²⁶ See Millennium Declaration, *supra* note 22, arts. 11-19; see also Millennium Development Goal 1, http://www.who.int/mdg/publications/mdg_report/en/ (last visited Feb 13, 2007).

²⁷ WHO 2003, *supra* note 4, at 7.

²⁸ WHO 2003, *supra* note 4, at 9.

²⁹ WHO 2003, *supra* note 4, at 10.

³⁰ WHO 2003, *supra* note 4, at 8.

³¹ World Health Report 2006, Fact file available at http://www.who.int/features/factfiles/sdh/02_en.html (last visited Feb 13, 2007).

³² *MDG Report 2006*, *supra* note 23, at 4.

³³ *Id.*

health.³⁴ Millennium Development Goals (MDG) 4, 5 and 6 speak directly to global health issues and set forth goals and targets to be achieved by 2015. Goal 4 focuses on reducing child mortality and sets a target of reducing the under-five child mortality rate by two-thirds. Goal 5 seeks to improve maternal health with the targeted aim of reducing the maternal mortality ratio by three-quarters. Goal 6 addresses HIV/AIDS, malaria and other infectious diseases and pledges to halt the spread and reduce the incidence of these diseases within the 15-year time period.³⁵

According to most recent data, there is some progress on all three of the health-related Goals. However, within that progress, there are severe, often growing inequalities among and within populations. For example, vaccination goals are being met in economically stable households with educated mothers, but lagging far behind in households with neither of these attributes.³⁶ Little progress has been achieved with respect to maternal mortality, especially in the regions where most maternal deaths occur.³⁷ With respect to infectious diseases, the statistics remain daunting. Although some countries have managed to reduce HIV infection rates, the overall rate continues to rise. The number of people living with and dying from HIV/AIDS continues to increase, despite greater access to antiretroviral drugs.³⁸ And new tuberculosis cases are on the rise, even after excluding those associated with AIDS.³⁹

The World Health Organization notes that the Millennium Development Goals impact global health well beyond the direct, quantifiable targets and measures. The WHO has highlighted the presence of the "10/90 disequilibrium," in which less than 10% of total global spending on health research is devoted to diseases that account for over 90% of the global disease burden. The last and perhaps most "global" of the Millennium Development Goal demands a global partnership for development that will strive to correct this disequilibrium.⁴⁰ This laudable goal has been demonstrably embraced by five countries – Denmark, Luxembourg, the Netherlands, Norway and Sweden – all of whom have met the UN target of contributing 0.7% of gross national income to the Millennium Development effort.⁴¹

³⁴ See generally WHO, Health and the Millennium Development Goals (2005) [hereinafter Health and MDG].

³⁵ See Millennium Development Goals 4-6, http://www.who.int/mdg/publications/mdg_report/en/ (last visited Feb 13, 2007).

³⁶ MDG Report 2006, *supra* note 23, at 11.

³⁷ MDG Report 2006, *supra* note 23, at 12. This is most marked in sub-Saharan Africa and Southern Asia where there have been only *de minimus* improvement in maternal mortality. *Id.*

³⁸ MDG Report 2006, *supra* note 23, at 14.

³⁹ MDG Report 2006, *supra* note 23, at 15.

⁴⁰ Health and MDG, *supra* note 34, at 62

⁴¹ MDG Report 2006, *supra* note 23, at 23.

This last Millennium Development Goal (Goal 8) addressing global partnerships highlights several target areas.⁴² These include improved access to affordable pharmaceutical drugs and new information and communications technologies. On the other side of the disequilibrium equation, developing countries have assumed ever-greater roles in the market and efforts to reduce trade barriers and foster improved access to drugs, therapies and other health products have been increasingly focused on by the World Trade Organization.⁴³ Access to essential drugs, especially those treating HIV/AIDS, has improved; between 2001 and 2005, the number of people on antiretroviral therapy in low and middle income countries increased five-fold.⁴⁴ Despite this, antiretroviral drugs reach one in five globally.⁴⁵ And although access to information and communication outpaces economic growth, there is a large digital divide between the developing and developed world.⁴⁶

As a result of the Millennium Development Goals, both the United Nations and the World Health Organization have grappled anew with the issue of global health.⁴⁷

Notably, the WHO, which had been languishing in terms of impact, found new relevance and power as the arbiter of the standards for global health.⁴⁸ The weighty health-related goals undertaken in the Millennium Declaration cry out for additional tools. Therein lays an opportunity to use long-standing human rights norms and laws as a building block towards reaching the Millennium Development Goals and further global health.

II. INTERNATIONAL HUMAN RIGHTS LAW: THE EVOLVING RIGHT TO HEALTH

⁴² Health and MDG, *supra* note 34, at 2-4.

⁴³ *Id.*

⁴⁴ MDG Report 2006, *supra* note 23, at 24.

⁴⁵ *Id.*

⁴⁶ MDG Report 2006, *supra* note 23, at 23. Other targets included in Millennium Goal 8 include: develop open, rule-based predictable, non-discriminatory trading and financial systems, address the special needs of least developed and landlocked countries, deal with debt problems of developing countries through national and international debt management, and develop and implement strategies for productive work for youth. See Millennium Development Goal 8, Target 12, http://www.who.int/mdg/publications/mdg_report/en/ (last visited Feb 13, 2007).

⁴⁷ Health and MDG, *supra* note 34, at 10.

⁴⁸ See Allyn L. Taylor, *supra* note 16, at 505; David P. Fidler, *supra* note 17, at 73. WHO has identified five major challenges in meeting the goal: strengthen health systems and make them responsive to the needs of the poor; ensure that health is prioritized within the overall development and economic policies; develop cost-effective strategies that address the most burdensome diseases and conditions; improve the quality of health data so that global monitoring will be possible in the future; and mobilize more resources for health in poor countries. See Health and MDG, *supra* note 34, at 7; see generally MDG Report 2006, *supra* note 23.

Health has been part of the modern human rights rhetoric dating back to the end of World War II.⁴⁹ As the post-War world considered the crimes against individuals and the genocide committed during the War, there arose a general consensus that human rights norms should be codified and set forth as a common standard to which all nations should aspire to and ultimately achieve.⁵⁰ Out of this general consensus, the United Nations was founded and included in its Charter the statement and agreement that all people are “born free and equal in dignity and rights.”⁵¹ These words of the charter were elaborated upon in 1948 with the Universal Declaration of Human Rights, the bedrock document of human rights.

The Universal Declaration of Human Rights (UDHR) sought to better define the rights and freedoms anticipated by the UN Charter.⁵² Under the UDHR, a certain quantum of rights accrues to individuals simply because they were sentient, intelligent human beings, regardless of their national origin, race or gender.⁵³ These human rights are viewed as universal entitlements to dignity and humanity that include freedom from slavery and freedom from torture.⁵⁴ The Universal Declaration is not a treaty, but a General Assembly resolution. Unlike a treaty that has been ratified by a critical number of signatories and becomes binding, a General Assembly resolution does not have binding forces in and of itself. It is, rather, an aspirational statement of agreed-upon international goals.⁵⁵

As is the case today, the General Assembly was unable to reach complete consensus. The Declaration was the result of lengthy negotiations and drafting compromises by the leaders, policy makers, and lawyers representing each of the states involved in the negotiation. The final product is a balancing act between achieving the greatest progress and getting the greatest possible number of signatories.⁵⁶ This same balancing act is repeated with respect to not only international human rights documents like the Universal Declaration, but also all international treaties and laws.

⁴⁹ See Stephen P. Marks, *The Evolving Field of Health and Human Rights: Issues and Methods*, 30 J. L. MED. & ETHICS 739, 739 (2002) (“The Second World War was the defining event for the internationalization of human rights”); see also Sofia Gruskin, *SARS, Is There a Government in the Cockpit: A Passenger's Perspective or Global Public Health: The Role of Human Rights*, 77 TEMP. L. REV. 313, 319-20 (2004).

⁵⁰ See Sofia Gruskin, *id.* at 319.

⁵¹ U.N. Charter art. 1, 13, 55, 62, 68, 73 and 76.

⁵² Universal Declaration of Human Rights, G.A. Res. 217A(III) U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. DOC A/810 (Dec 10, 1948) [hereinafter UDHR].

⁵³ Sofia Gruskin, *supra* note 49, at 319.

⁵⁴ *Id.*

⁵⁵ George P. Smith, *Human Rights and Bioethics, Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 VAND. J. TRANSNAT'L L. 1295, 1300 (2005).

⁵⁶ Michael J. Dennis & David P. Stewart, *Justiciability of Economic Social and Cultural Rights: Should There be an International Complaint Mechanism to Adjudicate the Rights to Food, Water, Housing and Health?*, 98 A.M.J.I.L. 462, 478 (2004).

The UDHR's language with respect to health drew upon the spirit of the United Nations Charter, written in 1945, and the World Health Constitution written in 1946. The preamble of the WHO Constitution states:

"[T]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."⁵⁷

This critical phrasing describes what is now termed the right to health. It was fleshed out and further described in Article 25 of the UDHR:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁵⁸

As is evidenced by this language, the concept of health was broadly defined and holistic, encompassing virtually all of what we now know as the "social determinants" of health and well-being.⁵⁹

However, despite this broad language, the right to health was less forceful than envisioned by many of the UN delegates of the day. Work on what should be included as essential human rights had been ongoing during the early years of the U.N. as it drafted its charter.⁶⁰ During that process, delegates from Latin America had framed the rights to health in stronger terms: "The State has a duty to maintain, or to ensure that there are maintained, comprehensive arrangements for the prevention of sickness and accident, and for the provision of medical care and of compensation for the loss of livelihood."⁶¹

Although the delegates from Latin America, notably those from Panama and Chile, submitted and argued for inclusion of a broad right to health in the Universal Declaration of Human Rights, the early draft language gave way to a more modulated right to health.⁶² From this draft language, promoted by Latin American delegates, to the final language in

⁵⁷ Constitution of the World Health Organization, opened for signature July 22, 1946, reprinted in World Health Organization, *Basic Documents* (40th ed. 1994), at 1; for a full discussion of the Preamble of the WHO Constitution, see generally David P. Fidler, *supra* note 17, at 60-64.

⁵⁸ Universal Declaration of Human Rights, art. 25.

⁵⁹ See Sofia Gruskin, *supra* note 49, at 326; See generally Hoda Rashad, *Promoting Global Action on the Social Determinants of Health*, 51 *DIABETES VOICE* 33 (2006).

⁶⁰ See generally MARY ANN GLENDON, *A WORLD MADE NEW, ELEANOR ROOSEVELT AND THE UNIVERSAL DECLARATION OF HUMAN RIGHTS* (2001).

⁶¹ American Law Institute, *Statement of Essential Human Rights*, in *AMERICAN LAW INSTITUTE SEVENTY-FIFTH ANNIVERSARY, 1923-1998*, at 285-86, (1998).

⁶² See Mary Ann Glendon, *The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea*, 16 *HARV. HUM. RTS. J* 27, 31-32 (2003).

the Declaration, we see the right to health change from being framed as a “positive right”, something that the State government has a duty to maintain and ensure, to being framed as a right that is somewhat hollow and bereft of any means of enforceable commitment. This is, in part, an inherent limitation of the nature of the document. As a Declaration, it has no binding effect on the parties. That said, unlike many subsequent declarations, the UDHR enjoys a more elevated status, largely because of its foundational role and universal acceptance.⁶³ Notably, the language of the Universal Declaration has been embraced by many nations and been incorporated into their national constitutions and/or articulated legal rights.⁶⁴

After the flurry of post-War interest in human rights, there was a period of little activity that persisted until the 1960s. However in the mid-60s, two treaties furthered the international approach to human rights: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.⁶⁵ Unlike the UDHR, the Covenants are legally binding upon the nation states that sign and ratify them.⁶⁶ However, ratification is an excruciatingly slow process. For example, the International Covenant on Civil and Political Rights was not ratified by the United States until 1992; the International Covenant on Economic, Social and Cultural Rights was signed by the US in 1992, but has not been ratified.⁶⁷ Even when a treaty or covenant has been ratified, it will bind only to the extent of any reservations a state has elected.⁶⁸ These reservations allow the state party to demur from specific articles within the treaty or covenant, thus restricting their responsibilities and duties under the treaty.

The International Covenant on Civil and Political Rights (ICCPR) does not specifically detail a “right to health”. It does, however, enumerate a number of other rights that relate directly and indirectly to health. These include the rights to life,⁶⁹ privacy,⁷⁰ liberty and security.⁷¹ Notably, “the inherent right to life,” as articulated in Article 6 of the ICCPR, is

⁶³ George P. Smith, *supra* note 55, at 1300.

⁶⁴ For example, South Africa has explicitly included a right to health in its Constitution.

⁶⁵ International Covenant on Civil and Political Rights, Dec 19, 1966, 000 U.N.T.S. 171 [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, Dec 16, 1966, 933 U.N.T.S. 3 [hereinafter ICESCR].

⁶⁶ See Sofia Gruskin, *supra* note 49, at 320.

⁶⁷ JUDITH ASHER, THE RIGHT TO HEALTH: A RESOURCE MANUAL FOR NGOS 9 (2004).

⁶⁸ *Id.*

⁶⁹ ICCPR, *supra* note 65, art. 6, art. 9.

⁷⁰ ICCPR, *supra* note 65, art. 17.

⁷¹ ICCPR, *supra* note 65, art. 9.

increasingly construed broadly.⁷² The meaning of the right to life under ICCPR has been elaborated upon in General Comment 6, a statement issued by the Human Rights Committee in 1982.⁷³ General Comment 6(1) cautions against a narrow view of the right to life.⁷⁴ The Comment specifically notes that protection of life requires states to take positive measures including efforts to reduce infant mortality and increase life expectancy,⁷⁵ especially with respect to eliminating malnutrition and epidemics.

The “inherent right to life” provided under the ICCPR actually results from a non-derogable prohibition against any arbitrary deprivation of life.⁷⁶ Indeed, the ICCPR requires states to immediately recognize and credit rights that have been termed non-derogable.⁷⁷ Not all of the rights in the ICCPR are non-derogable.⁷⁸ Some of the rights have inherent limitations; for example, Article 12 of the Covenant for Civil and Political Rights limits the right to freedom of movement when it imperils public health.⁷⁹ These limitations are typically construed narrowly.⁸⁰

The “right to health” is contained and detailed in the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁸¹ Article 12(1) of this Covenant echoes the preamble of the WHO stating: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁸²

Moving from the aspirational to the practical, Article 12(2) details some of the metrics used to assess the standard of health:

⁷² ICCPR General Comment 6, the Right to Life (Article 6) U.N. ESCOR Hum. Rts. Comm. 16th Sess. International Human Rights Instruments, P1, U.N. Doc. HRI/Gen/1/Rev. 1 (1994)[hereinafter General Comment 6].

⁷³ Dina Bogecho, *Putting It to Good Use: the International Covenant on Civil and Political Rights and Women's Right to Reproductive Health*, 13 S. CAL. L. & WOMEN'S STUD. 229, 345 (2004). The Human Rights Committee is the treaty monitoring body for the ICCPR. One of its prerogatives is to issue clarifying comments interpreting various provisions of the Convention. See description of treaty monitoring bodies, *infra* at 10-11.

⁷⁴ ICCPR General Comment 6, *supra* note 72, at 5.

⁷⁵ *Id.*

⁷⁶ See ICCPR, *supra* note 65, art. 1 and 4.

⁷⁷ Included among such non-derogable rights are the right to be free from torture, slavery, and involuntary servitude, the right to a fair trial, and freedom of thought. See ICCPR, *supra* note 65, art. 4.

⁷⁸ ICCPR, *supra* note 65, art. 4.

⁷⁹ See ICCPR, *supra* note 65, art. 4.

⁸⁰ See Sofia Gruskin, *supra* note 49, at 323; see also Siracusa Principles on the Limitations and Derogation Provisions in the International Covenant on Civil and Political Rights, U.N. ESCOR Sub-Commission on the Prevention and Protection of Minorities, Annex, 41st Sess. Agenda Item 18, U.N. Doc. E/CN.4/1985/4 (1985).

⁸¹ ICESCR, *supra* note 65.

⁸² ICESCR, *supra* note 65, art. 12(1).

The steps to be taken by the States Parties to the present covenant to achieve the full realization of this right shall include those necessary for:

- a) The provision for the reduction of the stillbirth rate and of infant mortality and for healthy development of the child;
- b) The improvement of all aspects of environment and industrial hygiene;
- c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases
- d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁸³

Unlike the rights enumerated in the ICCPR, the rights in the ICESCR are not non-derogable. Partially because of the differences between countries in terms of development, economic/financial status, baseline health status, and social conditions, the ICESCR rights are subject to progressive realization:

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 appropriate means, including particularly the adoption of legislative measures.⁸⁴

Progressive realization allows for variation in the degree of compliance and speed of movement towards full implementation of the right. Progressive realization allows a country to embrace the rights and duties of the treaty or covenant, even though they are not able to effect them immediately. What is required, however, is purposeful movement toward full realization.⁸⁵

Generally government obligations with respect to the right to health fall into three categories of action: to respect, to protect, and to fulfill.⁸⁶ Respecting the right to health means that the government must refrain from taking actions that inhibit or interfere with people's ability to enjoy their right.⁸⁷ Protecting the right to health means that the state must seek to

⁸³ ICESCR, *supra* note 65, art. 12(2).

⁸⁴ ICESCR, *supra* note 65, art. 2(1).

⁸⁵ See JUDITH ASHER, *supra* note 67, at 35.

⁸⁶ See JUDITH ASHER, *supra* note 67, at 35-37; Michael J. Dennis & David P. Stewart, *supra* note 56, at 490-91.

⁸⁷ See JUDITH ASHER, *supra* note 67, at 35-37; Michael J. Dennis & David P. Stewart, *supra* note 56, at 490-91.

protect the people from having their rights infringed by third parties, such as private industry, pharmaceutical companies, researchers, health care providers or vendors.⁸⁸ Fulfilling the right to health means that the government is required to take positive action to implement the right to health by adopting a national health policy that allocates public resources to correct deficiencies in health facilities, goods and services.⁸⁹ At the present time, most of the obligations are effectively at the “respect” or “protect” stage of realization rather than the more positive rights-oriented “fulfill” stage.

Both the ICCPR and ICESCR have treaty monitoring committees composed of independent experts elected by the states; the ICCPR is monitored by the Human Rights Committee (HRC) and the ICESCR by the Committee on Economic, Social and Cultural Rights (CESCR).⁹⁰ The monitoring process provides for committee review of country reports submitted that document compliance and/or progress towards meeting treaty obligations.⁹¹ The Committees are also responsible for issuing detailed interpretations of provisions in the Covenants; these General Comments provide more explanation of the treaty obligations and elaborate upon the contemporaneous meaning of those obligations.⁹²

Most recently, in 2000, the ICESCR's right to health was elaborated on and clarified at length by General Comment 14, issued by the Committee on Economic, Social and Cultural Rights (CESCR):

The notion of “the highest attainable standard of health” in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be

⁸⁸ See JUDITH ASHER, *supra* note 67, at 35-37; Michael J. Dennis & David P. Stewart, *supra* note 56, at 490-91.

⁸⁹ See JUDITH ASHER, *supra* note 67, at 35-37; Michael J. Dennis & David P. Stewart, *supra* note 56, at 490-91.

⁹⁰ Dina Bogecho, *supra* note 73, at 239; *see generally* Michael J. Dennis & David P. Stewart, *supra* note 56.

⁹¹ See JUDITH ASHER, *supra* note 67, at 128-29. The General Comments discussed *infra* typify such General Comments.

⁹² JUDITH ASHER, *supra* note 67, at 129 (noting the CESCR's process in adopting General Comment 14). *See also* discussion on General Comment 6 interpreting the ICCPR, *supra* note 72, at 8-9.

understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.⁹³

General Comment 14 goes on to acknowledge that the notion of what constitutes “health” has changed significantly since the original drafting of the ICESCR in 1966.⁹⁴ It embraces a broader definition of health that includes social determinants of health, including access to safe water and food, adequate nutrition and housing, healthy environmental conditions, access to health-related education and information.⁹⁵ It also acknowledges that the state of world health has been dramatically altered by rapid population growth, new pathogens (HIV/AIDS, emerging and re-emerging infectious diseases), and the fact that chronic diseases have become more deeply entrenched and widespread.⁹⁶

General Comment 14 sets forth a framework for the progressive realization of the right to health.⁹⁷ The goal of this framework is to guide nations as they make the policy, legislative, and administrative changes necessary to realize the right to health. There are universal immediate minimum core obligations that states must provide: immunizations against major infectious diseases; measures to prevent, treat and control epidemic and endemic diseases; essential medicines; reproductive, maternal and child health care; essential primary health care; non-discriminative access to health facilities; equitable distribution of health facilities, goods, and services; access to safe, nutritionally adequate food; access to safe water and housing.⁹⁸ Many of these resonate with the health-related Millennium Development Goals. In addition, governments must provide education and access to information about health and appropriate training for health professionals.⁹⁹ Finally, when formulating national health policy, governments must adopt an epidemiologically sound and population-relevant public health strategy.¹⁰⁰

⁹³ Committee on Economic, Social and Cultural Rights, *general comment 14, The Right to the Highest Attainable Standard of Health*. E/C.12/2000/4, para. 9 [hereinafter General Comment 14] <http://cesr.org/generalcomment14> (last visited Feb 13, 2007).

⁹⁴ *Id.*

⁹⁵ *Id.*, para. 11.

⁹⁶ *Id.*, para. 10.

⁹⁷ *Id.*

⁹⁸ *Id.*, paras 43-45.

⁹⁹ *Id.*

¹⁰⁰ *Id.* General Comment 14 also emphatically states that states have an immediate obligation to ensure non-discrimination. Governments must abolish any laws or policies that allow discrimination that affects the right to health, refrain from engaging in any discriminatory practice in implementing laws and policies, and implement measures to counter-balance past discrimination against those previously subjected to discrimination. *See id.* para. 18.

While these minimum core obligations must be committed to immediately, it is often impossible for a developing country to fully implement their commitment. Despite Comment 14, there is little capacity to fully realize these minimum core obligations in terms of practical implications. At this point in time, they are seen as fervent aspirations waiting for sufficient economic investment to bring them into reality.¹⁰¹ Nevertheless, Comment 14 evidences an evolving expectation of more concrete and resolute accomplishments on the road to progressive realization – an expectation that has recently been further honed in the 2005 International Health Regulations issued by WHO.

The ICESCR differs from the ICCPR in terms of enforcement capacity. The ICCPR has an Optional Protocol, which allows for individual or group complaints to be heard and considered by the Human Rights Committee.¹⁰² While the country is subject to this complaint process only if it has signed on the Optional Protocol, this individual complaint process provides a forum for adjudication of human rights violations.¹⁰³ There is no parallel Optional Protocol and individual complaint process for the ICESCR.¹⁰⁴ Thus an aggrieved individual or group will be unable to seek validation and enforcement of their rights, unless they can do so collaterally, by alleging a violation of the right to life,¹⁰⁵ or through a national forum in a country that has incorporated the right to health into its Constitution or public health legislation.¹⁰⁶

Proponents of a complaint mechanism for the ICESCR argue that the absence of enforcement capacity has marginalized economic, social and cultural rights and limited movement toward full realization.¹⁰⁷ Others note that the reason for the absence of enforcement is obvious and appropriate given that economic, social and cultural rights are so complex and dependent upon so many determinants that justiciability would be

¹⁰¹ George P. Smith, *supra* note 55, at 1318.

¹⁰² International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), GAOR, U.N. Doc. A/6316 (1966).

¹⁰³ See Dina Bogecho, *supra* note 73, at 239.

¹⁰⁴ See Michael J. Dennis & David P. Stewart, *supra* note 56, at 465.

¹⁰⁵ See e.g. Ms. Yekaterina Pavlovna Lantsova v. The Russian Federation, Communication No. 763/1997 (July 22, 1996), CCPR/C/74/D/763/1997 (before the UN Human Rights Committee).

¹⁰⁶ For example, South Africa has included a number of human rights in its Constitution, including a broad and far-reaching right to health. See Constitution of South Africa (adopted May 8, 1996, amended Oct 11, 1996), <http://www.polity.org.za/html/govdocs/constitution/saconst.html?rebookmark=1> (last visited Feb 13, 2007). South Africa has also passed legislation to control drug prices with the aim of improving access to antiretroviral drugs for the treatment of HIV/AIDS. A challenge by multinational pharmaceutical companies followed in which they alleged violation of WTO intellectual property agreements; however, as a result of significant negative public media attention, the challenge was ultimately dropped. See Leslie London, *Human Rights and Public Health: Dichotomies or Synergies in Developing Countries? Examining the Case of HIV in South Africa*, 30 J.L. MED. & ETHICS 677, 678 (2002).

¹⁰⁷ See Michael J. Dennis & David P. Stewart, *supra* note 56, at 453.

impossible.¹⁰⁸ Despite the lack of a formal individual complaint process, the right to health has enjoyed significant attention and advocacy through pressure exerted by NGOs, the media, and a variety of local, national and international commissions.¹⁰⁹ In addition, the U.N. appointed a Special Rapporteur to monitor and assess efforts of governments to progressively realize the highest attainable standard of physical and mental health.¹¹⁰

The net result of these two foundational covenants is an implicit hierarchy of rights: civil and political rights include the right to life, liberty, security of persons, freedom of movement, the right not to be subjected to torture, cruel, inhumane or indecent treatment or punishment, or to arbitrary arrest and detention.¹¹¹ Many of these rights are non-derogable and immediately in force upon ratification. They also may be justiciable internationally through the Human Rights Committee if the country has entered into the Optional Protocol. Economic, social and cultural rights include the right to attain the highest possible standard of health, to work, to social security, to adequate food, clothing, housing, education and to enjoy the benefits of scientific progress and its application. These rights are subject to progressive realization and while the Committee for Economic, Social and Cultural Rights provides monitoring there is no international complaint process. However, the CESCR has provided strident guidance to States Parties through Comment 14, laying out a concrete set of minimum core objectives.

The two Covenants reflect the dichotomy of the political world in the mid-twentieth century. In 1966, the Cold War was the backdrop as the treaty language was negotiated and debated. There was a basic ideological split on the issue of whether or not economic, cultural and social rights, including the right to health, inevitably dictated a particular ideology, at that time Socialism, but more significantly for certain delegations, Communism.¹¹² In addition, the concept of developing countries was much clearer than it had been in the immediate post-War era and their fundamental resource needs were evident, sweeping and unable to be addressed, even if there had been an impetus to do so by the wealthier, industrialized countries.¹¹³

¹⁰⁸ See Michael J. Dennis & David P. Stewart, *supra* note 56, at 496.

¹⁰⁹ Sofia Gruskin, *supra* note 49, at 321.

¹¹⁰ See U.N. Comm'n on Human Rights, Res. 2002/31, 49th mtg. (2002). See also JUDITH ASHER, *supra* note 67, at 128-30 (discussion of role of the Special Rapporteur).

¹¹¹ Dina Bogecho, *supra* note 73, at 232.

¹¹² See Michael J. Dennis & David P. Stewart, *supra* note 56, at 477 (discussing the debate regarding ideology and the evolution of the two Covenants).

¹¹³ See Michael J. Dennis & David P. Stewart, *supra* note 56, at 514 (noting that even today effective realization of economic, social and cultural rights is a global challenge of gigantic proportions).

Building upon and following these two major Covenants, there have been numerous targeted conventions and declarations addressing human rights and more particularly the health issues incumbent in these rights. Among the specifically targeted conventions are: the International Convention on the Elimination of All Forms of Racial Discrimination (1965);¹¹⁴ the Convention on the Elimination of All Forms of Discrimination Against Women (1979);¹¹⁵ the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984);¹¹⁶ and the Convention on the Rights of the Child (1989).¹¹⁷ At this point in time, every country in the world is party to at least one Convention or treaty that includes rights relevant to health and has responsibility and accountability for human rights as they relate to health.¹¹⁸

III. THE CONVERGENCE OF HUMAN RIGHTS AND GLOBAL HEALTH

Health and human rights have evolved along parallel, but distinctly separate tracks. Both began as state-centric, but have become internationalized in the wake of the HIV/AIDS epidemic.¹¹⁹ Contemporary globalization results in expanded health risks that transcend national borders in their origin and impact. Such risks may include emerging and re-emerging infectious diseases, global environmental degradation, food safety, and an array of non-communicable diseases as well as trade in harmful commodities like tobacco.¹²⁰ While it may be difficult to link diseases to their countries of origin, these diseases often arise from impoverished countries that are plagued by hunger, unsafe waters, and unsanitary dangerous environments – these are the very nations that are the focus of the Millennium Development Goals. And the fact that these new global diseases are mighty threats to industrialized, developed countries has fueled their interest in funding and supporting the health-related Goals.

Disease spreads quickly, wreaking havoc and endangering populations regardless of development or relative wealth.¹²¹ HIV/AIDS, SARS, and Avian Flu are convincing testimonials to this undeniable fact. The fluidity

¹¹⁴ International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106(XX) U.N. Doc. A/6014 (Dec 21, 1965).

¹¹⁵ Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. Doc. A/RES/34/180 (Dec 18, 1979).

¹¹⁶ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, G.A. Res. 39/46, U.N. Doc. A/RES/39/46 (Dec 10, 1984).

¹¹⁷ Convention on the Rights of the Child, G.A. Res. 44/25, Annex, U.N. Doc. A/RES/25/44/Annex (Dec 12, 1989).

¹¹⁸ Sofia Gruskin, *supra* note 49, at 320.

¹¹⁹ *See Id.* at 313.

¹²⁰ Allyn L. Taylor, *supra* note 16, at 500.

¹²¹ Laurie Z. Asher, *supra* note 18, at 141.

of travel causes the spread of disease, but it also provides opportunity for the enhancement of international law.¹²² International law has gained new prominence as a tool for multilateral cooperation in the public health field as states increasingly realize the need to complement domestic action in the health sector with cross-sector and cross-border action to protect the health of their populations.¹²³

The new International Health Regulations (IHR) are an example of the new focus of international health law – one that embraces human rights as inextricably linked to health. The IHR explicitly incorporate human rights norms. Notably Article 3(1) states: “The new IHR shall be implemented with full respect for the dignity, human rights and fundamental freedoms of persons.”¹²⁴ Other provisions within the IHR speak to “taking into consideration the gender, socio-cultural, ethnic, or religious concerns.”¹²⁵ While the IHR provide for numerous compulsory examination, vaccination, and other health measures, the compulsory nature is tethered to a realistic appraisal of the public health risk as determined by a defined “decision instrument”.¹²⁶ The IHR impose minimum obligations on States Parties for core surveillance and response capacities. These include duties to detect, assess, notify and report disease events and respond promptly and effectively to public health risks and emergencies.¹²⁷ These obligations and duties are to be in place after a five-year grace period. There is no capacity for a progressive realization such as that found with respect to the right to health in the ICESCR.¹²⁸

Unlike earlier iterations of International Health Regulations, the new regulations have an expanded scope that is predicated upon a model of global governance.¹²⁹ This model is characterized by multilateral collaboration as well as engagement with an expanded universe of non-state stakeholders and policy makers.¹³⁰ The convergence of human rights and health that is integral to the IHR is also consonant with achieving optimal population benefit in global trade, international environmental improvement, and human security.¹³¹

¹²² *Id.* at 143-44.

¹²³ Allyn L. Taylor, *supra* note 16, at 501.

¹²⁴ World Health Assembly, Revision of the International Health Regulations, WHA58.3 23 May 2005, art. 3(1) [hereinafter IHR].

¹²⁵ *Id.* art. 32.

¹²⁶ David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325, 369-70 (2005).

¹²⁷ IHR, *supra* note 124, at Annex 1. See David P. Fidler, *id.* at 373.

¹²⁸ David P. Fidler, *id.* at 373.

¹²⁹ David P. Fidler, *id.* at 326.

¹³⁰ For example, the IHR allow the WHO authority to access information from non-governmental sources and the power to declare public health emergencies. See David P. Fidler, *id.* at 376.

¹³¹ David P. Fidler, *id.* at 325.

In the trade sector, expanded international trade and the increasing role of WTO treaties provide links between health, human rights and trade law. For example, access to pharmaceutical drugs and the health implications have been a dominant issue in the Trade Related Aspect of Intellectual Property Rights (TRIPS) agreement.¹³² Under the TRIPS agreement, WTO members have the capacity to grant compulsory patent licenses without the patent holder's consent.¹³³ The TRIPS agreement was further clarified in 2001 by the Doha Declaration, which clarified that TRIPS was to be implemented with an eye to protecting public health and, in particular, to promote access to medicine for all.¹³⁴ The Doha Declaration was adopted by the WTO in 2003 and, although it remains embattled, it represents a multilateral trade decision that attempts to balance the rights of patent holders with the profound health needs of the developing world for affordable access to essential medications.¹³⁵

Exploitation of children and other vulnerable populations as labor also is increasingly viewed as a global health and human rights issue. The Convention on the Rights of the Child, which has been signed by all but two nations, addressed child labor as a health risk.¹³⁶ And the WHO has declared that improving occupational health is critical to improving the health of the world's populations.¹³⁷ Similarly, environment degradation is increasingly framed as a global health and human rights issue.¹³⁸

With respect to international human security, disease has been recognized as a more formidable killer than war, with the power to completely destabilize governments.¹³⁹ This knowledge has confounded the traditional approach of national security that has focused on military and external threats imposed upon a country or population's interests, safety and survival.¹⁴⁰ Health is linked to security issues in the context of naturally occurring epidemics, such as SARS and HIV/AIDS, as well as unnaturally occurring health threats resulting from bioterrorism, nuclear proliferation

¹³² See Allyn L. Taulor, *supra* note 16, at 501; Frederick M. Abbott, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*, 99 AM. J. INT'L L. 317, 317 (2005).

¹³³ See Frederick M. Abbott, *id.* at 319.

¹³⁴ See Declaration on the TRIPS Agreement and Public Health (Nov 14 2001), <http://www.wto.org> (last visited Feb 13, 2007).

¹³⁵ Frederick M. Abbott, *supra* note 132, at 358; see also Allyn L. Taulor, *supra* note 16, at 502.

¹³⁶ See Convention on the Rights of the Child, *supra* note 117, art. 32(1).

¹³⁷ World Health Organization, Declaration on Occupational Health For All (Oct 14, 1994), http://www.who.int/occupational_health/publications/declaration/en/ (last visited Feb 13, 2007).

¹³⁸ See generally David P. Fidler, *Challenges to Humanity's Health: The Contributions of International Environmental Law to National and Global Public Health*, 31 ENVIRONMENTAL LAW REPORTER 10048 (2001) (role of international environmental and human rights law and its role in promoting and protecting global health).

¹³⁹ See Judith Asher, *supra* note 18, at 135.

¹⁴⁰ See David P. Fidler, *Public Health and National Security in the Global Age: Infectious Diseases, Bioterrorism, and Realpolitik*, 35 GEO. WASH. INT'L L. REV. 787, 787 (2003).

and other weapons of human destruction.¹⁴¹ The linkage of health with global security was manifested by the U.N. Security Council's categorization of HIV/AIDS in sub-Saharan Africa as an issue of international peace and security.¹⁴² Similarly, WHO has cast infectious diseases as a global security threat.¹⁴³

IV. CONCLUSION

Global health and human rights have been conspicuously linked over the last several years with the United Nations system paying increasing attention to the interrelationship of the two as the ICCPR and ICESCR have matured and tailored rights instruments have addressed the rights of particular vulnerable populations.¹⁴⁴ Human rights work is shifting from a narrow, legalistic focus on civil and political rights to a broader rights approach encompassing economic, social and cultural rights.¹⁴⁵ Global health is increasingly viewed as integral to global security; infection is a mighty weapon, whether wielded by nature or terrorism. The role of human rights in achieving global health is recognized by global governance efforts such as the recently issued International Health Regulations.¹⁴⁶ In recent years, the WTO has sought to balance trade objectives with health risks and evidenced unwillingness to trade off global health to further trade. Similarly international labor and environmental policies and regulation often cite global health and human rights as underlying motivating factors for change and multilateral agreement.

This broader rights-based approach is fostered by globalization, which demands a global governance model with both coordinated intergovernmental action and interaction with non-governmental stakeholders.¹⁴⁷ This governance model is also evident in modern international trade, labor, environmental, and human security efforts, all of which are interwoven with a health dimension. The protection of health and provision of human rights is no longer seen as merely a humanitarian aim, but rather a global aim that is part and parcel of multilateralism and interdependence.

¹⁴¹ Allyn L. Taylor, *supra* note 16, at 501; *see also* David P. Fidler, *id.* at 792.

¹⁴² David P. Fidler, *id.* at 793.

¹⁴³ *Id.*

¹⁴⁴ Allyn L. Taylor, *supra* note 16, at 502.

¹⁴⁵ Paul Farmer & Nicole Gastineau, *Rethinking Health and Human Right: Time for a Paradigm Shift*, 30 J. L. MED. & ETHICS 655, 656 (2002).

¹⁴⁶ David P. Fidler, *supra* note 126, at 386.

¹⁴⁷ Allyn L. Taylor *supra* note 16, at 500.

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