

A HUMAN RIGHT TO HEALTH: IS THERE ONE AND, IF SO, WHAT DOES IT MEAN?

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It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for.
—United Nations Secretary-General Kofi Annan¹

The human right to health, maybe more than any other right, uncovers disparities in respect for the human dignity of persons, based on race or ethnicity, socioeconomic status, geographic location, gender or sexual orientation, age, mental health, disability, and other characteristics. This article discusses the place of the human right to health in international law: whether a human right to health exists at all and, if so, what that means. It will illustrate that while the right to health is not universally legally enforceable the realization of the right to health is indeed progressing. The 1948 Universal Declaration of Human Rights is not as such legally enforceable, yet it has led to at least universal awareness of human rights. The number of states that are parties to legally enforceable human rights treaties and that have enacted domestic human rights laws continues to grow, as does the network of values-based nongovernmental organizations and movements.

This article first provides an explanation of the meaning of “human rights” and “the right to health.” It examines to what extent both are enforceable under international law and achievable through non-legal sanctions or rewards. The second part of the article addresses recent world events that may not intuitively evoke the right to health, but in fact constitute violations of the most vulnerable people’s right to health by the most powerful, and illustrate the

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¹ WHO, *25 Questions and Answers on Health and Human Rights*, Health & Human Rights Publication Series, Issue No. 1 (2002), www.who.int/hhr/NEW37871OMSOK.pdf.

breadth of issues that implicate the human right to health.

I. A Human Right to Health

A. Inherent Human Rights

The Preamble to the 1948 United Nations Declaration of Human Rights (UDHR) recognizes “the inherent dignity and . . . equal and inalienable rights of all members of the human family.”² The Declaration resulted from the horrific experience of the Second World War, after which the international community determined to create a road map to guarantee the human rights of every individual.³ It does not purport to create rights; rather, it recognizes basic, inalienable rights and fundamental freedoms with which each human being is born. A state’s refusal to recognize a human right does not mean the right does not exist, and a state can violate human rights even when laws authorize its actions. The UDHR is not a binding legal document. Rather, it is an aspirational one – one that, however, in many respects, now reflects customary international law. The universal innate human rights it articulates are, in any event, not legally enforceable by means established within the UDHR.

As expressed by the UDHR, health is an inherent and inviolable universal human right, set forth in article 25:

- (1) 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.

² Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).

³ *The Universal Declaration of Human Rights: History of the Document*, UNITED NATIONS, <http://www.un.org/en/documents/udhr/history.shtml> (Feb. 5, 2015).

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(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.⁴

Article 3 adds, “Everyone has the right to life, liberty and security of person.”⁵

B. International Law

Traditionally, we think of a “law” as a legally enforceable rule that must be obeyed or the violator suffers the consequences, such as jail, fines, or damages. Given this way of thinking, a right to health in international law would mean a legally enforceable rule with which all nations must comply. Under this definition, there is no such legal right that binds all nations. However, many nations do recognize a right to health under international treaties.

1. Treaties

One source of international law is a binding treaty between two or among many nations.⁶ While the UDHR itself it is not legally binding, the United Nations in 1966 transformed the provisions of the Declaration into two sets of legally binding obligations in the International Covenant on Civil and Political Rights (ICCPR),⁷ to be discussed in more detail later, and the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁸

The right to health is found in ICESCR article 12:

⁴ Universal Declaration of Human Rights, *supra* note 2, at art. 25.

⁵ *Id.* at art. 3.

⁶ Statute of the International Court of Justice art. 38(1)(a), appended to U.N. Charter, June 26, 1945.

⁷ Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).

⁸ Covenant on Economic, Social and Cultural Rights (hereinafter ICESCR), *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976).

1. 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.
2. 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 the healthy development of the child;
 - (b) The improvement of all aspects of environmental 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.⁹

As shown by the chart below, 164 countries are states parties that have ratified the Covenant, consenting to be bound by the ICESCR, to enact compatible domestic measures, and to report regularly to a monitoring committee on how they are implementing the enumerated rights.¹⁰ Six states, including the U.S., have signed but not ratified the Covenant, meaning they have not yet consented to be bound, but intend to proceed to ratification and are obligated in good faith to refrain from actions contrary to the treaty's object and purpose.¹¹ Twenty-eight states have taken no action.¹² In 18 states that have ratified the Optional Protocol to the ICESCR, individuals can petition the committee claiming violation of their rights; 28

⁹ *Id.* art. 12.

¹⁰ *See Status of Ratification Interactive Dashboard: International Covenant on Economic, Social and Cultural Rights*, OFFICE OF THE HIGH COMM'R ON HUMAN RIGHTS (OHCHR), <http://indicators.ohchr.org/> (last visited Aug. 13, 2015).

¹¹ *Id.* *See* Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331, available at <https://treaties.un.org/doc/Publication/UNTS/Volume%201155/volume-1155-I-18232-English.pdf>.

¹² *Status of Ratification Interactive Dashboard: International Covenant on Economic, Social and Cultural Rights*, *supra* note 10.

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states have signed but not yet ratified the Optional Protocol, and 151 have taken no action on it.¹³

*Chart of ICESCR Ratification*¹⁴

Country Status

Ratified (164) **Signed not Ratified (6)** **No Action (27)**



Unlike civil and political rights protected in the ICCPR, which states parties must immediately implement, the ICESCR requires states to realize economic, social and cultural rights progressively, to the maximum of its available resources, as provided in ICESCR article 2(1):

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available

¹³ *Status of Ratification Interactive Dashboard*, *supra* note 10 (Optional Protocol to the International Covenant on Economic, Social and Cultural Rights); Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, G.A. Res. 63/117, art. 2, U.N. Doc. A/RES/63/117 (Dec. 10, 2008).

¹⁴ *Status of Ratification Interactive Dashboard*, *supra* note 10 (Optional Protocol to the International Covenant on Economic, Social and Cultural Rights).

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.¹⁵

The often-cited reason for this latitude is that while civil and political rights are characterized as predominantly “negative rights” with which signatory states must not interfere, economic, social and cultural rights are characterized as “positive rights” that require signatory states to expend resources to fulfill them.¹⁶ The requirement of only progressive, instead of immediate, realization of the right to health over time does not excuse states parties from meaningful progress; rather, they have a continuing and specific obligation to take deliberate and concrete steps toward full realization as effectively and expeditiously as possible.¹⁷

The U.N. Committee on Economic, Social, and Cultural Rights explains that, as with all human rights, the right to health imposes three levels of obligations: to respect, protect, and fulfill those rights.¹⁸ “The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties [e.g. private parties, corporations, or other states] from interfering” with the enjoyment of the right to health.¹⁹ The obligation to fulfill requires them “to adopt appropriate legislative, administrative, budgetary, judicial, promotional and

¹⁵ ICESCR, *supra* note 8, at art. 2(1).

¹⁶ See *History and Categories of Human Rights: A Brief History of Human Rights*, COLUM. UNIV. MAILMAN SCH. OF PUB. HEALTH, http://healthandrights.ccnmtl.columbia.edu/human_rights/history_categories_human_rights.html (last visited Aug. 13, 2015).

¹⁷ U.N. Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, ¶¶ 30-31, 22d Session, Apr. 25-May 12, 2000, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en.

¹⁸ *Id.* ¶ 33.

¹⁹ *Id.* ¶¶ 9, 33.

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other measures” to fully realize the right to health, including making available essential and minimum levels of health facilities, goods and services, and request assistance from other States, civil society and humanitarian organizations.²⁰

The right to health is not a right to be healthy, but rather a right to the highest attainable standard of health; individuals’ socioeconomic and biological preconditions, genetics, susceptibility to illness, and practice of risky or unhealthy lifestyles are important factors.²¹ The Human Rights Committee views the “minimum essential level” of realization of the right to health as states parties’ core obligation to ensure include at least: access to health services, facilities and goods; freedom from hunger; access to an adequate supply of safe water, basic shelter, and sanitation; provision of essential drugs; fair distribution of these items; and adoption and implementation of an evidence-based national public health plan and strategy that includes monitoring with indicators and benchmarks.²²

The right to health is also implied in the right to life guaranteed in other treaties. For example, ICCPR article 6(1) provides: “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.”²³ State parties must respect and implement ICCPR rights in “good faith.”²⁴ U.N. Human Rights Committee General Comment No. 6 notes that the right to life often is interpreted too narrowly.²⁵

²⁰ *Id.* ¶¶ 33, 38.

²¹ *Id.* ¶¶ 8-9. See also OHCHR, Fact Sheet 31, The Right to Health 5 (2008) available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

²² *General Comment No. 14*, *supra* note 17, ¶ 43 (citing the Alma-Ata Declaration, Report of the International Conference on Primary Health Care 24-25, 34 (Sept. 6-12, 1978)). See also Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT’L L.J. 325, 337 (2003).

²³ ICCPR, *supra* note 7 art. 6(1).

²⁴ U.N. Human Rights Comm’n, *The Nature of the General Legal Obligation Imposed on States Parties to the Covenant: General Comment No. 31*, 80th Session, ¶ 3, U.N. Doc. CCPR/C/21/Rev1/Add. 13, (Mar. 29, 2004), available at <http://www.unhcr.ch/tbs/doc.nsf/0/58f5d4646e861359c1256ff600533f5f>.

²⁵ U.N. Human Rights Comm’n, *The Right to Life (Art. 6): General Comment No. 6*, 16th Session, ¶¶ 1, 5, U.N. Doc. HII/GEN/1/Rev.9 (Vol. I) (Apr. 30, 1982),

The right to life legally obligates State parties to take positive measures that protect not just life itself, but the quality of life.²⁶ The application of the right to life in health-related circumstances will be discussed in more detail in Part II.

The right to health is found in many more international instruments, including the following, which are quoted in some length for an understanding of the extent of the international commitment to the right to health.

The Arab Charter on Human Rights, article 39, provides:

1. The States parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the right of the citizen to free basic health-care services and to have access to medical facilities without discrimination of any kind.
2. The measures taken by States parties shall include the following:
 - (a) Development of basic health-care services and the guaranteeing of free and easy access to the centres that provide these services, regardless of geographical location or economic status;
 - (b) efforts to control disease by means of prevention and cure in order to reduce the mortality rate;
 - (c) promotion of health awareness and health education;
 - (d) suppression of traditional practices which are harmful to the health of the individual;
 - (e) provision of basic nutrition and safe drinking water for all;
 - (f) Combating environmental pollution and providing proper sanitation systems;
 - (g) Combating smoking and abuse of drugs and psychotropic substances.²⁷

available at <http://www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3>.

²⁶ See *id.* ¶ 5.

²⁷ League of Arab States, Arab Charter on Human Rights art. 39, *opened for*

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The Association of South East Asian Nations (ASEAN) Human Rights Declaration article 29(1) proclaims, “Every person has the right to the enjoyment of the highest attainable standard of physical, mental and reproductive health, to basic and affordable health-care services, and to have access to medical facilities.”²⁸

The Convention on the Rights of the Child, article 24, provides in pertinent part:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - (a) To diminish infant and child mortality;
 - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of

signature May 22, 2004 (entered into force Mar. 15, 2008), *reprinted in* 12 INT’L HUM. RTS. REP. 893 (2005), *available at* <http://www1.umn.edu/humanrts/instate/loas2005.html>.

²⁸ Ass’n S.E. Asian Nations, ASEAN Human Rights Declaration, *opened for signature* Nov. 19, 2012, *available at* <http://www.asean.org/news/asean-statement-communications/item/asean-human-rights-declaration>. ASEAN’s members are “Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People’s Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand and the Socialist Republic of Viet Nam.” *Id.*

environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.²⁹

The Convention on the Elimination of All Forms of Racial Discrimination reads:

Article 5

States Parties undertake to . . . guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . .:

(e) (iv) The right to public health, medical care, social security and social services³⁰

The Convention on the Elimination of All Forms of Discrimination Against Women provides:

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the

²⁹ Convention on the Rights of the Child art. 24, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990).

³⁰ Convention on the Elimination of All Forms of Racial Discrimination art. 5, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969).

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field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connexion with pregnancy confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

...

Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to each woman the right:

...

(b) To have access to adequate health care facilities, including information, counselling and services in family planning;

...

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.³¹

The Convention on the Rights of Persons with Disabilities, article 25, provides:

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States

³¹ Convention of the Elimination of All Forms of Discrimination Against Women arts. 12, 14, *opened for signature* Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981).

Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- c) Provide these health services as close as possible to people's own communities, including in rural areas;
- d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of

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disability.³²

The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, the “Protocol of San Salvador,” ratified by 16 states and signed by 5 states, provides in article 10:

Right to Health

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
 - a. Primary health care, that is, essential health care made available to all individuals and families in the community;
 - b. Extension of the benefits of health services to all individuals subject to the State’s jurisdiction;
 - c. Universal immunization against the principal infectious diseases;
 - d. Prevention and treatment of endemic, occupational and other diseases;
 - e. Education of the population on the prevention and treatment of health problems, and
 - f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.³³

The African Charter on Human and Peoples Rights, article 16, provides:

³² Convention on the Rights of Persons with Disabilities art. 25, *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3 (entered into force May 3, 2008).

³³ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights “Protocol of San Salvador,” art. 10, *opened for signature* Nov. 17, 1988, O.A.S.T.S. No. 69 (entered into force Nov. 16, 1999).

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.³⁴

States that ratify these conventions and charters agree to be bound by them.³⁵ Thus, they are compliance-based approaches to realize the right to health.

None of the treaties above is dedicated solely to health care like the single-focus Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination against Women, and Convention on the Rights of Persons with Disabilities. A Framework Convention on Global Health (FCGH) was proposed in 2008³⁶ and United Nations Secretary-General Ban Ki-Moon endorsed it in 2011.³⁷ The Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI), a global civil-society coalition with members from the global North and South, and whose core principle is global health justice, is working to advance the FCGH.³⁸ The Convention would create “an innovative framework for clarifying national and global responsibilities to ensure the right to health . . . , codify these obligations and create accountability for their effective

³⁴ African Charter on Human and Peoples Rights art. 16, *opened for signature* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) (entered into force Oct. 21, 1986), *available at* http://www.achpr.org/files/instruments/achpr/banjul_charter.pdf.

³⁵ *See Status of Ratification Interactive Dashboard*, *supra* note 10.

³⁶ *See* Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO. L.J. 331, 336 (2008).

³⁷ *See* Lawrence O. Gostin & Eric A. Friedman, *Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice*, 13 YALE J. HEALTH POL'Y, L. & ETHICS 1, 54 (2013) (citing U.N. Secretary-General, *Uniting for Universal Access: Towards Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths: Rep. of the Secretary-General*, ¶ 73 U.N. Doc A/65/797 (Mar. 2011)).

³⁸ Gostin & Friedman, *supra* note 37, at 1 n.d1.

implementation.”³⁹

2. Customary International Law

Customary international law is another type of international law⁴⁰ that is legally enforceable. Unlike treaties that bind only ratifying states, customary international law binds all states.⁴¹ Customary law arises from a general practice of states that is accepted as law because it reflects very widespread practice of states, including specially affected states, as well as *opinio juris*—i.e. states obey it because they believe they are legally obligated to do so.⁴² At the time of the writing of this article, there is not yet a right to health that has matured into customary international law.

C. Domestic Constitutions

At least 115 national constitutions recognize the right to health or the right to health care.⁴³ For example, South Africa’s constitution provides in chapter 2, section 27:

- (1) Everyone has the right to have access to
 - a. health care services, including reproductive health care;
 - b. sufficient food and water; . . .
- (2) The State must take reasonable legislative and other measures, within its available resources, to

³⁹ *Id.* at 6-7.

⁴⁰ Statute of the International Court of Justice, *supra* note 6, art. 38(1)(b).

⁴¹ W. MICHAEL REISMAN, MAHNOUSH H. ARSANJANI, SIEGFRIED WIESSNER, & GAYL S. WESTERMAN, *INTERNATIONAL LAW IN CONTEMPORARY PERSPECTIVE* 14-15 (2004). An exception is that customary international law does not bind states that persistently objected to the purported new rule during its formation. *Id.* at 15.

⁴² *Id.* at 14-15, referring to the *North Sea Continental Shelf Case* (F.R.G. v. Den./F.R.G. v. Neth.), 1969 I.C.J. 4, 41.

⁴³ Fact Sheet 31, *supra* note 21, at 10.

achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.⁴⁴

Another example is Ecuador's constitution, which provides in article 32:

Health is a right guaranteed by the State and whose fulfillment is linked to the exercise of other rights, among which the right to water, food, education, sports, work, social security, healthy environments and others that support the good way of living.

The State shall guarantee this right by means of economic, social, cultural, educational, and environmental policies; and the permanent, timely and non-exclusive access to programs, actions and services promoting and providing integral healthcare, sexual health, and reproductive health. The provision of healthcare services shall be governed by the principles of equity, universality, solidarity, interculturalism, quality, efficiency, effectiveness, prevention, and bioethics, with a gender and generational approach.⁴⁵

Six other constitutions include health-related state duties, such as development of health services or specific budgetary allocation to health.⁴⁶ One example is the Constitution of India (1950), which requires the State to improve nutrition, raise the standard of living, and improve public health.⁴⁷

The clear constitutional trend is toward greater protection of health rights.⁴⁸ Only 33% of constitutions adopted before 1970

⁴⁴ S. AFR. CONST., 1996.

⁴⁵ CONSTITUCIÓN DE LA REPÚBLICA DEL ECUADOR art. 32.

⁴⁶ Fact Sheet 31, *supra* note 21, at 10.

⁴⁷ INDIA CONST. art. 47.

⁴⁸ Mark Wheeler, *A Constitutional Right to Health Care: Many Countries Have It, But Not the U.S.*, UCLA NEWSROOM, July 18, 2013, <http://newsroom.ucla.edu/releases/a-constitutional-right-to-health-247449>.

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addressed any health right; 60% of those adopted between 1970 and 1979 included the right to medical care, health or public health; 75% of constitutions adopted in the 1980's and 94% of those adopted in the 1990's addressed one or more of these rights; and of 33 constitutions adopted between 2000 and 2011 only one did not protect any health right.⁴⁹

D. What Else is Law?

A broad concept of law extends beyond formal rules of law to what “laws,” whether formal or customary—even unwritten—are obeyed in real life.⁵⁰ An every-day example is the unwritten rules for standing in line: who gets to cut in, and for what reasons?⁵¹ The unwritten rules create expectations of behavior with rewards for following those expectations and sanctions for violating them, “the carrot and the stick.”⁵²

The New Haven Jurisprudence view provides an alternative view to considering “law” only as the formal rule of law: to see law as a process of decisions over time, i.e. messages emanating from persons endowed with *authority*, expected to make decisions in the community, and vested with *control intent*, i.e. the threat of severe deprivation of values in case of non-compliance and the promise of high indulgences or benefits in the case of compliance.⁵³ When we see law as a process, look outside the bounds of formal law, and take cultural sensitivities into account, we see that changes are happening through progressive realization of human rights, including the right to health. U.N. Committee on Economic, Social and Cultural Rights General Comment No. 14 (1) recognizes that “[t]he realization of the

⁴⁹ *Id.*

⁵⁰ See Siegfried Wiessner, *The New Haven School of Jurisprudence: A Universal Toolkit for Understanding and Shaping the Law*, 18 ASIA PAC. L. REV. 45, 47-48 (2010).

⁵¹ See Rachele Von Anders, *Waiting in Line Etiquette*, ETIQUETTE GUIDE, Aug. 15, 2010, <http://etiquette-guide.com/waiting-in-line-etiquette/#sthash.EjzLQpOH.dpbs>.

⁵² Wiessner, *supra* note 50, at 45.

⁵³ *Id.* at 47-48.

right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments.”⁵⁴ States often make “agreements” sometimes called “gentlemen’s agreements,” the breach of which does not violate the law; sometimes, however, they are more effective than legal rules in state practice.⁵⁵

Approaches based on values rather than on compliance with binding laws are particularly important for countries such as the United States. One of the cultural sensitivities of the United States is that sovereignty is critically important to us as a nation. We do not want to be told what to do and hesitate to ratify treaties that empower other countries to legally enforce them, particularly treaties on economic, social, and cultural issues that require expenditure of resources. Consequently, we have not bound ourselves by the ICESCR or the American Convention on Human Rights (ACHR) and its Additional Protocol in the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador), both of which address economic, social and cultural issues.⁵⁶ We have taken no action on the Protocol of San Salvador.⁵⁷ We have signed the ICESCR, but not ratified it.⁵⁸ We both signed and ratified the ICCPR, which covers civil and political issues, but Congress then declared it was not self-

⁵⁴ *General Comment No. 14, supra* note 17, ¶ 1.

⁵⁵ Eckart Klein, Member, U.N. Human Rights Committee 1995-2002, Intercultural Human Rights LL.M. Class Lecture, The Covenant on Civil and Political Rights, St. Thomas University School of Law (Oct. 13, 2014).

⁵⁶ *See Status of Ratification Interactive Dashboard, supra* note 10 (regarding the U.S. failure to ratify the ICESCR); *Additional Protocol to the American Convention On Human Rights in the Area of Economic, Social and Cultural Rights “Protocol of San Salvador,”* INTER-AM. COMM’N ON HUMAN RIGHTS, <https://www.cidh.oas.org/Basicos/English/Basic6.Prot.Sn%20Salv%20Ratif.htm> (last visited May 9, 2015) (listing all ratifying and signatory states to the Protocol).

⁵⁷ INTER-AM. COMM’N ON HUMAN RIGHTS, *supra* note 56.

⁵⁸ *See Status of Ratification Interactive Dashboard, supra* note 10 (United States). The United States also has signed but not ratified the following multilateral human rights treaties: Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of the Child, and International Convention on the Rights of Persons with Disabilities. *Id.*

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executing, meaning that it is unenforceable in U.S. courts unless Congress enacts domestic laws to implement it.⁵⁹

Nevertheless, we see ourselves as champions of human rights.⁶⁰ The U.S. pays attention to world opinion. The U.S. participates in the U.N.'s Universal Periodic Review, for which it submits a report to the U.N. High Commissioner for Human Rights every 4-5 years. This allows the U.S. to respond to criticism from other countries—or not—based on U.S. prioritization of values and resources. In its 2010 report to the Human Rights Committee, the U.S. wrote:

In addition to accepting human rights obligations under . . . treaties to which it is a party, the United States has made human rights commitments through numerous other instruments, including the 1948 Universal Declaration of Human Rights and the 1948 American Declaration of the Rights and Duties of Man.

The United States regularly submits lengthy and detailed reports on its implementation of several of the human rights treaties listed above, specifically the International Covenant on Civil and Political Rights, the Convention against Torture, the Convention on the Elimination of All Forms of Racial Discrimination, and the two Optional Protocols to the Convention on the Rights of the Child.⁶¹

It is interesting to observe that the U.S. Report's section on health does not use "right-to-health" language.⁶²

⁵⁹ David Kaye, *State Execution of the International Covenant on Civil and Political Rights*, 3 U.C. IRVINE L. REV. 95, 96 (2013).

⁶⁰ See Report of the United States of America Submitted to the U.N. High Commissioner for Human Rights in Conjunction with the Universal Periodic Review 2 (2011), available at <http://www.state.gov/documents/organization/146379.pdf>.

⁶¹ *Id.* at 26.

⁶² See *id.*, § IV. 2 Health, ¶¶ 69-73.

The following discussion provides examples of nonbinding, values-based approaches⁶³ to realize the right to health, which complement binding laws. The Declaration of Alma-Ata, issued at the 1978 International Conference on Primary Health Care in Alma-Ata, U.S.S.R. (now Kazakhstan), two years after the ICCPR and ICESCR came into force, proclaimed that:

[H]ealth, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.⁶⁴

Sixty-seven NGOs attended the conference⁶⁵ and 134 countries signed the Declaration.⁶⁶ The Declaration set a target of the year 2000 to attain “a level of health that will permit . . . all peoples of the world . . . to lead a socially and economically productive life,” and stated that “primary health care is the key to attaining this target”⁶⁷ Although the Declaration is not legally

⁶³ Because the Universal Declaration of Human Rights itself is nonbinding, it relies on a values-based approach rather than a compliance-based approach.

⁶⁴ Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, Sept. 6-12, 1978, *available at* http://www.who.int/publications/almaata_declaration_en.pdf.

⁶⁵ *Primary Health Care: 30 Years Since Alma-Ata*, UNICEF, http://www.unicef.org/malaysia/SOWC09__Alma_Atta_Primary_Health_Care.pdf (last visited Aug. 14, 2015).

⁶⁶ JONATHAN WOLFF, *THE HUMAN RIGHT TO HEALTH* 8 (2012) (discussing the history of the Declaration of Alma-Ata).

⁶⁷ Declaration of Alma-Ata, *supra* note 64, § V.

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Id. § VI.

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binding, it is often called the most important moment in the human right to health's development because it extended and reaffirmed the right to health and placed it in the context of its economic and social determinants.⁶⁸ The declaration "was groundbreaking because it linked the rights-based approach to health to a viable strategy for attaining it."⁶⁹

The World Health Organization (WHO) directs and coordinates health matters within the United Nations system.⁷⁰ The 1948 WHO Constitution declares health a fundamental human right and commits to ensuring the highest attainable level of health for all.⁷¹ WHO provides global health leadership, shapes the agenda for health research, sets standards and norms, articulates evidence-based and ethical policy options, provides technical support to countries, and monitors situations and assesses health trends.⁷²

The United Nations Millennium Development Goals (MDGs), adopted in 2000 by 189 heads of state, set forth a plan for countries to work with development partners to reduce hunger and poverty, poor health, environmental degradation, lack of access to clean water, and gender inequality, with special focus on women and children.⁷³ They establish eight goals to reach by 2015, as well as various progress-monitoring indicators.⁷⁴

Three of the goals directly relate to health: MDG 4, a two-thirds reduction in child mortality; MDG 5, a three-quarters reduction in maternal deaths and universal reproductive health care access; and MDG 6, to stop and reverse the incidence of HIV/AIDS, achieve universal HIV/AIDS treatment access by 2010, and stop and

⁶⁸ WOLFF, *supra* note 66, at 139.

⁶⁹ *Primary Health Care: 30 Years Since Alma-Ata*, *supra* note 65.

⁷⁰ *About WHO: What We Do*, WORLD HEALTH ORG., <http://www.who.int/about/en/> (last visited May 9, 2015).

⁷¹ *Constitution of WHO: Principles*, WORLD HEALTH ORG., <http://www.who.int/about/en/> (last visited May 9, 2015).

⁷² *About WHO*, *supra* note 70.

⁷³ *Accelerating Progress Towards the Health-Related Millennium Development Goals*, 2 WHO Doc. WHO/DGO/2010.2 (2010), available at http://www.who.int/topics/millennium_development_goals/who_dgo_2010_2/en/.

⁷⁴ *Id.*

reverse the spread of malaria and other diseases.⁷⁵ Other MDGs that indirectly address health are MDG 1, reducing hunger by half; MDG 7, reducing by half the number of persons who lack sustainable access to basic sanitation and safe drinking water; MDG 8, access in developing countries to affordable essential drugs; MDG 2, primary education; and MDG 3, empowering women.⁷⁶

The WHO explains what is involved in a “health system” required to progress toward the health-related MDG goals:

A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health.

- The six building blocks of a health system are health services and infrastructure, the health workforce, a health information system, medical products, vaccines & technologies, health financing, and leadership & governance.
- A well functioning health system responds in a balanced way to the population’s health needs and expectations by addressing key constraints in the six building blocks, to provide equitable access to people-centred care, with a special focus on women, girls and children.⁷⁷

The WHO states that full realization of the human right to health would be universal health coverage, which would mean that all persons would, without financial hardship, receive needed health services including not only treatment, but prevention, promotion, rehabilitation, and palliative care.⁷⁸

Universal [health] coverage is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men. Universal health coverage is

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.* at 10.

⁷⁸ *Id.*

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the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness.⁷⁹

The United Nations Resolution on Universal Health Coverage, a nonbinding document, was adopted unanimously in December 2012 by the United Nations General Assembly.⁸⁰ Earlier in 2012, the Mexico City Political Declaration on Universal Health Coverage,⁸¹ the Bangkok Statement on Universal Health Coverage,⁸² and the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector⁸³ were adopted.⁸⁴ These developments indicate a gathering of support with the recognition that health is an essential element and indicator in sustainable international development.⁸⁵

II. The Human Rights to Health – In the News

The breadth of issues that implicate the right to health and its interdependence with other human rights is demonstrated in events that may not intuitively bring to mind the right to health. This second section of the article discusses five of these.

⁷⁹ Margaret Chan, Director-General of the World Health Organization, Address to the World Health Assembly (May 21, 2012), *available at* http://www.who.int/dg/speeches/2012/wha_20120521/en/.

⁸⁰ Global Health and Foreign Policy, G.A. Res. 67/81, U.N. Doc. A/RES/67/81 (Dec. 12, 2012), *available at* http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81.

⁸¹ Mexico City Political Declaration on Universal Health Coverage (Apr. 2, 2012).

⁸² Bangkok Statement on Universal Health Coverage (Jan. 28, 2012).

⁸³ Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector (July 5, 2012).

⁸⁴ Press Release, World Health Org., Universal Health Coverage: Health: Essential for Sustainable Development, *available at* http://www.who.int/universal_health_coverage/un_resolution/en/ (last visited May 9, 2015).

⁸⁵ *Id.*

A. Beijing Air Pollution Embarrasses Officials

In November 2014, more than twenty world leaders including Vladimir Putin and Barack Obama met in Beijing for the Asia-Pacific Economic Cooperation summit (APEC).⁸⁶ Air pollution in Beijing was so bad that the air was “a gauzy white” and registered “very unhealthy” on the air quality scale.⁸⁷ Many of the 30,000 runners in an October marathon wore masks to protect themselves from the smog engulfing the city.⁸⁸ Embarrassed city officials ordered shut-down of factories within 125 miles of Beijing’s center and restricted automobile operation, construction, and crematorium operation to lessen the air pollution during the summit.⁸⁹

In 2010, air pollution caused more than 3.2 million deaths, increasing from the 1990 level of 80,000 deaths.⁹⁰ In Hong Kong in the years 2005 through 2011, 7,240 persons died prematurely from air pollution; air pollution victims experienced 528,388 avoidable days’ hospitalization and made 49.26 million pollution-related doctor visits.⁹¹

The Convention on Long-Range Transboundary Air Pollution (CLRTAP)⁹² sets forth general principles of international cooperation to abate air pollution.⁹³ Fifty-one countries including the United States

⁸⁶ Jonathan Kaiman, *Beijing Attempts to Cut Air Pollution for APEC Summit*, THE GUARDIAN, Nov. 4, 2014, <http://www.theguardian.com/world/2014/nov/04/beijing-smokescreen-hide-pollution-apec>.

⁸⁷ *Id.*

⁸⁸ *See id.*

⁸⁹ *See id.*

⁹⁰ Heather R. Croshaw, *The “Right to Health” and “Right to Life”: Positive Obligations for Controlling Air Pollution in Hong Kong in Clean Air Foundation v. Hksar*, 15 VT. J. ENVTL. L. 450, 454 (2014); Brad Plumer, *Air Pollution Now Kills More People than High Cholesterol*, WASH. POST, Dec. 20, 2012, <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/12/20/airpollution-now-kills-more=-people-than-high-cholesterol/>.

⁹¹ Croshaw, *supra* note 90; Plumer, *supra* note 90.

⁹² Convention on Long-Range Transboundary Air Pollution, *opened for signature* Nov. 13, 1979, 1302 U.N.T.S. 217 (entered into force Mar. 16, 1983).

⁹³ *The 1979 Geneva Convention on Long-Range Transboundary Air Pollution*, U.N. ECON. COMM’N FOR EUROPE, http://www.unece.org/env/lrtap_hl.html (last

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are parties, and thirty-two have signed but not yet ratified it; China is not among them.⁹⁴ However, China ratified the ICESCR in 2001.⁹⁵ Thus, while China is not bound by CLRTAP to reduce air pollution, it is bound by ICESCR article 2(1) “to take steps . . . to the maximum of its available resources” including legislation and international cooperation and assistance to progressively achieve realization of Covenant rights⁹⁶ including article 12(2)(b) to “improve[] all aspects of environmental . . . hygiene” and article 12(1) to respect, protect and fulfill the right to “the highest attainable standard” of physical and mental health.⁹⁷

China took steps in that direction during the November 2014 APEC summit, when President Xi Jinping and President Obama jointly announced new targets to cut greenhouse gas emissions.⁹⁸ By 2025, the U.S. will cut greenhouse gas emissions 26-28%, and China will peak CO₂ emissions and increase the share of non-fossil fuel energy to about 20% by around 2030.⁹⁹ China’s targets will require it to deploy more additional nuclear, solar, wind and other forms of zero-emission energy capacity than all of its coal-fired power plants can produce today.¹⁰⁰

In *Clean Air Foundation v. HKSAR*, an environmental NGO sued the Hong Kong Special Administrative Region (HKSAR) in 2007, alleging that HKSAR failed its legal duty to guarantee Hong Kong citizens’ right to life and right to health, violating Hong Kong’s Basic Law, Bill of Rights, and the ICCPR and ICESCR.¹⁰¹

visited April 10, 2015).

⁹⁴ U.N. Treaty Collection, Convention on Long-Range Transboundary Air Pollution, Status April 10, 2015, 06:53:41 EDT, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=XXVII-&chapter=27&lang=en.

⁹⁵ *Status of Ratification Interactive Dashboard*, *supra* note 10 (ICESCR).

⁹⁶ ICESCR, *supra* note 8, at art. 1.

⁹⁷ *Id.*

⁹⁸ Press Release, Office of the Press Secretary, Fact Sheet: U.S.-China Joint Announcement on Climate Change and Clean Energy Cooperation, (Nov. 11, 2014), *available at* <https://www.whitehouse.gov/the-press-office/2014/11/11/fact-sheet-us-china-joint-announcement-climate-change-and-clean-energy-c>.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Clean Air Found. v. Hong Kong Special Admin. Region*, [2007] 35

The claim also alleged that HKSAR failed to pass legislation and policies adequate to mitigate and control air pollution.¹⁰² The opinion accepted the justiciability of a claim that HKSAR had an affirmative duty to protect the rights to life and health by combating air pollution, even if it was not an absolute duty to ensure an immediate end to air pollution.¹⁰³ Other countries including Bangladesh, Greece, Macedonia, Nepal, Nigeria, Peru, and Uganda have legal precedent for the right to life and/or health as the basis for claims of harm from air pollution.¹⁰⁴

*B. Corporation Dumps Toxic Waste Dumped in
Côte d'Ivoire; 100,000 Victims*

A different kind of pollution that affects health is the export to and dumping of toxic waste in developing countries by developed countries and transnational corporations.¹⁰⁵ In 2006, multinational company Trafigura dumped toxic waste in Abidjan, Côte d'Ivoire, resulting in more than 100,000 victims seeking medical help.¹⁰⁶ The toxic waste was 84,000 tons of coker gasoline, for which international law bans transboundary movement.¹⁰⁷ It originated in Mexico, then was smuggled into Brownsville, Texas for storage and

H.K.C.F.I. 757, ¶ 1, 6, 16–17 (H.K.), available at <http://www.hklii.hk/cgibin/sinodisp/eng/hk/cases/hkcfi/2007/757.html?stem=&synony0ms=&query=clean%20air%20foundation>.

¹⁰² *Id.* ¶ 1.

¹⁰³ *Id.* ¶¶ 17, 19. The petitioners ultimately lost the case because they focused on the implementing mechanisms to improve air quality rather than the law itself, and the court ruled that was a policy/political matter for HKSAR and not for the judiciary. *Id.* ¶¶ 41, 43.

¹⁰⁴ See *Air Pollution*, GLOBAL HEALTH & HUMAN RIGHTS DATABASE, <http://www.globalhealthrights.org/tag/air-pollution/> (last visited Apr. 14, 2015).

¹⁰⁵ See Cyril Uchenna Gwam, *Human Rights Implications of Illicit Toxic Waste Dumping from Developing Countries Including the U.S.A., Especially Texas to Africa, in Particular, Nigeria*, 38 T. MARSHALL L. REV. 241, 241 (2013).

¹⁰⁶ *Report Slams Failure to Prevent Toxic Waste Dumping in West Africa*, AMNESTY INT'L (Sept. 25, 2012), <https://www.amnesty.org/en/articles/news/2012/09/report-slams-failure-prevent-toxic-waste-dumping-west-africa/>.

¹⁰⁷ Gwam, *supra* note 105, at 261.

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loaded onto Panamanian-registered tanker Probo Koala, owned by a Greek shipping company.¹⁰⁸ Aboard the ship, Trafigura stripped the Sulphur out of the gasoline with soda in a process called “caustic washing,” producing naphtha that it sold for \$19 million profit.¹⁰⁹ The waste from this process contained dangerous substances sodium sulphide, sodium hydroxide, and phenols.¹¹⁰

Trafigura originally brought the waste to the Netherlands, but Trafigura did not offload it there because it thought the price quoted to properly treat it was too high.¹¹¹ Dutch authorities were concerned about the toxic waste but let it leave the Netherlands, which violated Dutch legal obligations.¹¹² Ultimately it was offloaded in Abidjan, Côte d’Ivoire, which was not a member of the Basel Convention.¹¹³

Subcontractors spread the waste in the city and surrounding areas over a three-week period in public dumps, waste grounds, and on roadsides in populated areas.¹¹⁴ Its toxic gas burned people’s skin and lungs and caused severe vomiting and headaches.¹¹⁵ At least 17 people died and 30,000 suffered injuries.¹¹⁶

Côte d’Ivoire held two Trafigura executives and charged them with violating laws against poisoning, but released them in 2007, when Trafigura settled with the Ivorian government for the cleanup,¹¹⁷ and in return, was granted immunity from prosecution.¹¹⁸ Côte d’Ivoire brought Ivorian contractors to trial, and one who dumped 500 tons was convicted and imprisoned for 20 years.¹¹⁹ The

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at n.81.

¹¹¹ *Report Slams Failure to Prevent Toxic Waste Dumping in West Africa*, *supra* note 106.

¹¹² *Id.*

¹¹³ Gwam, *supra* note 105, at 261.

¹¹⁴ *Id.* at 263.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 265.

¹¹⁸ *Report Slams Failure to Prevent Toxic Waste Dumping in West Africa*, *supra* note 106.

¹¹⁹ Gwam, *supra* note 105, at 265.

30,000 victims sued Trafigura in the U.K., and Trafigura settled without admitting liability.¹²⁰ The Ivorian prime minister resigned over the toxic waste scandal.¹²¹ In 2007, Trafigura agreed to pay the Ivorian government U.S. \$198 million for cleanup without admitting any liability.¹²² In 2009, Trafigura agreed to pay \$46 million to claimants, still denying any liability.¹²³

In most cases, multinational corporations and developed countries intentionally dump toxic wastes in developing countries that lack facilities to monitor toxic waste movement, or to process toxic wastes, which could lessen the harm to their citizens' health and life.¹²⁴ They drastically reduce their costs by disposing of waste in developing countries. In the 1990's, disposal cost for a ton of hazardous waste in Africa averaged between \$2.50 and \$50, compared to \$100 to \$2,000 in industrialized countries.¹²⁵ Corporations and countries that produce toxic waste illicitly or openly use cash and other inducements to eliminate resistance from authorities in the receiving countries.¹²⁶

For example, in 1988, U.S. and European pharmaceutical companies and tanneries asked Guinea Bissau to take 15 million metric tons of hazardous waste over 5 years for \$600 million.¹²⁷ That offer was four times Guinea's GNP and twice the amount of its foreign debt.¹²⁸ Guinea "postponed" the agreement after Guinean officials were imprisoned for their involvement earlier that year in importing toxic incinerator ash from Philadelphia as "raw material

¹²⁰ *Report Slams Failure to Prevent Toxic Waste Dumping in West Africa*, *supra* note 106.

¹²¹ Gwam, *supra* note 105, at 265.

¹²² *Id.* at 266.

¹²³ *Id.*

¹²⁴ *Id.* at 257.

¹²⁵ *Id.* at 260 (citing Katherina Kummer, *Transboundary Movement of Hazardous Wastes at the Interface of Environment and Trade* (U.N. Env't Programme 1994)).

¹²⁶ *Id.* at 259.

¹²⁷ Gwam, *supra* note 105, at 259-60 (citing Ilona Cheyne, *Africa and International Trade in Hazardous Waste*, 6 *AFR. J. INT'L & COMP. L.* 3 493-503 (1994)).

¹²⁸ *Id.*

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for bricks” and burying it near the state capital.¹²⁹

States that receive toxic waste and are members of the ICESCR bear a responsibility to protect their citizens from health hazards of foreign-state or corporate dumping. Article 12(2)(b) of the ICESCR, the right to healthy natural and workplace environments, includes, *inter alia*, “the prevention and reduction of the population’s exposure to harmful substances such as radiation and harmful chemicals or other detrimental conditions that directly or indirectly impact on human health.”¹³⁰ Additionally, there are two international conventions on toxic waste, the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal¹³¹ and the Bamako Convention on the Ban of the Import into Africa and the Control of Transboundary Movement and Management of Hazardous Wastes within Africa.¹³² Nigeria and most other African countries have not yet domesticated the conventions to protect their environment.¹³³ These conventions define hazardous wastes as those with one or more of the following characteristics: “explosive, flammable, oxidizing, poisonous, infectious, corrosive, toxic and exotoxic.”¹³⁴

Both conventions define “exotoxic” as “substances or wastes, which, if released, present or may present immediate or delayed adverse impacts to the environment by means of bioaccumulation and/or toxic effects upon biotic systems.”¹³⁵ Exotoxic waste, after it is disposed, can produce another substance that has hazardous characteristics.¹³⁶ An example is waste electrical and electronic equipment that the U.S. regularly exports to Nigeria and other

¹²⁹ *Id.* at 269-70

¹³⁰ *General Comment No. 14, supra* note 17, ¶ 15.

¹³¹ Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal, Mar. 22, 1989, 28 I.L.M. 649 (entered into force May 5, 1992).

¹³² Bamako Convention on the Ban of the Import into Africa and the Control of Transboundary Movement and Management of Hazardous Wastes within Africa, Jan. 29, 1991, 30 I.L.M. 773.

¹³³ Gwam, *supra* note 105, at 241.

¹³⁴ *Id.* at 242.

¹³⁵ Basel convention, *supra* note 131; Bamako Convention, *supra* note 132.

¹³⁶ Gwam, *supra* note 105, at 242.

developing countries as “used” or “second-hand “equipment, which yields a hazardous substance called leachate.¹³⁷

Illicit dumping of toxic wastes was first recognized by consensus as a human rights issue at the 1993 Vienna World Conference on Human Rights.¹³⁸ The Vienna Declaration and Programme of Action recognized that toxic waste adversely affects human rights to health and life.¹³⁹ A U.N. Special Rapporteur was appointed in 1995 to monitor and investigate illicit toxic waste movement and produce an annual list of transnational corporations and countries engaged in illicit dumping.¹⁴⁰ The Special Rapporteur also produces an annual census of persons killed, maimed and affected adversely,¹⁴¹ providing evidence to hold dumpers liable and make them compensate victims. The Protocol on Liability and compensation for Damage Resulting from Transboundary Movement of Hazardous Wastes and their Disposal, which opened for signature in 2000, is a comprehensive regime to determine liability and ensure prompt, adequate compensation.¹⁴² So far, 13 states are signatories and 11 have ratified the Protocol.¹⁴³

Since 1995, the U.N. Human Rights Council has twice expanded the Special Rapporteur’s mandate, which now encompasses not only toxic waste movement and dumping, but the entire life cycle of hazardous products from manufacturing to

¹³⁷ Gwam, *supra* note 105, at 242-43 (citing CYRIL U. GWAM, TOXIC WASTE AND ENVIRONMENTAL RIGHTS VIOLATION: THE CASE OF NIGERIA’S MARITIME ENVIRONMENT (2011)).

¹³⁸ *Id.* at 250; World Conference on Human Rights, June 14-25, 1993, Vienna Declaration and Programme of Action, U.N. Doc. A/CONF.157/23 (July 12, 1993).

¹³⁹ Vienna Declaration, *supra* note 138, at part I, ¶ 11.

¹⁴⁰ Adverse Effects of the Illicit Movement and Dumping of Toxic and Dangerous Products and Wastes on the Enjoyment of Human Rights, C.H.R. Res. 1995/81, ¶ 7, U.N. Doc. E/CN.4 (Mar. 8, 1995).

¹⁴¹ *Id.*

¹⁴² Protocol on Liability and Compensation for Damage Resulting from Transboundary Movement of Hazardous Wastes and their Disposal, *opened for signature* Mar. 6, 2000, Doc. UNEP/CHW.1/WG.1/9/2, *available at* https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=XXVII-3-b&chapter=27&lang=en (last visited May 8, 2015).

¹⁴³ *Id.*

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disposal.¹⁴⁴ The mandate includes human rights issues related to transnational corporations, victim assistance and rehabilitation, the scope of national legislation, human rights implications of transfers of industries and technology among countries, and questions regarding ambiguities in international instruments that permit hazardous waste movement and dumping, and international regulatory gaps.¹⁴⁵ The rapporteur's title is now "Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes."¹⁴⁶

Toxic waste dumping is an instructive example of the interdependence of human rights. The adverse effect of toxic waste dumping on the right to health "cuts across civil, political, economic, social, and cultural rights," implicating rights to life, safe and healthy working conditions, environmental/industrial hygiene, security, privacy, adequate standard of living, housing, food, education and development.¹⁴⁷

¹⁴⁴ Gwam, *supra* note 105, at 253-55; Mandate of the Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes, H.R.C. Res. 2011/11, U.N. Doc. A/HRC/RES/18/11 (Oct. 13, 2011), *available at* <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/G11/166/61/PDF/G1116661.pdf?OpenElement>; Mandate of the Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes, H.R.C. Res. A/HRC/21/17, U.N. Doc. A/HRC/RES/21/17 (Oct. 22, 2012), *available at* <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/G12/181/54/PDF/G1218154.pdf?OpenElement>.

¹⁴⁵ *Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes: The Mandate of the Special Rapporteur*, U.N. HUMAN RIGHTS, <http://www.ohchr.org/EN/Issues/Environment/ToxicWastes/Pages/SRToxicWastesIndex.aspx> (last visited May 8, 2015).

¹⁴⁶ Mandate of the Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes, H.R.C. Res. 2011/11, U.N. Doc. A/HRC/RES/18/11 (Oct. 13, 2011), *available at* <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/G11/166/61/PDF/G1116661.pdf?OpenElement>.

¹⁴⁷ *Id.* at 257.

C. Deadly Collapse of Bangladesh Garment Factory

Like corporations and developed countries that dispose of toxic waste in developing countries to drastically reduce their costs, corporations contract production to suppliers who use factories in Bangladesh and other developing countries to increase their profits. Labor there is cheap¹⁴⁸ and workers' wages are among the world's lowest.¹⁴⁹

In 2005, a sweater factory in Bangladesh collapsed, killing 64 and injuring 80.¹⁵⁰ In November 2012, a fire in the Tarzeen Fashions multi-floor garment factory in Dhaka, Bangladesh, killed at least 111 persons.¹⁵¹ The factory had no outside fire exit.¹⁵² The majority of the garments the factory produced were to be sold at Wal-Mart.¹⁵³ Fatal factory fires are common in the garment manufacturing sector in Bangladesh, where 4,500 factories employ more than two million people in overcrowded conditions with lax safety standards and overcrowding.¹⁵⁴ Bangladesh, second only to China in clothing exports, is notorious for poor fire safety.¹⁵⁵ Clean Clothes Campaign, an Amsterdam-based anti-sweatshop advocacy group, reported in 2012 that since 2006, over 500 workers had already died

¹⁴⁸ Syed Zain Al-Mahmood & Shelley Banjo, *Deadly Collapse in Bangladesh*, WALL ST. J., Apr. 24, 2013, <http://www.wsj.com/articles/SB10001424127887324874204578441912031665482>.

¹⁴⁹ See Vikas Bajaj, *Fatal Fire in Bangladesh Highlights the Dangers Facing Garment Workers*, N.Y. TIMES, Nov. 25, 2012, http://www.nytimes.com/2012/11/26/world/asia/bangladesh-fire-kills-more-than-100-and-injures-many.html?_r=0&_r=1.

¹⁵⁰ Al-Mahmood & Banjo, *supra* note 148.

¹⁵¹ *Dhaka Bangladesh Clothes Factory Fire Kills More Than 100*, BBC News, Nov. 25, 2012, <http://www.bbc.com/news/world-asia-20482273>? (last updated Mar. 9, 2015 10:54 AM).

¹⁵² *Id.*

¹⁵³ Syed Zain Al-Mahmood, Tripti Lahiri, & Dana Mattioli, *Bangladesh Fire: What Wal-Mart's Supplier Network Missed*, WALL ST. J., DEC. 10, 2012, <http://www.wsj.com/articles/SB10001424127887324024004578169400995615618>.

¹⁵⁴ *Dhaka Bangladesh Clothes Factory Fire*, *supra* note 151.

¹⁵⁵ Bajaj, *supra* note 149.

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in factory fires.¹⁵⁶

In April 2013, a few months after the Tarzeen Fashions fire, an eight-story garment factory building named Rana Plaza in Bangladesh that housed 5,000 workers collapsed, killing hundreds of people.¹⁵⁷ By May 11, the death toll had risen to 1,115 people.¹⁵⁸ Workers there made clothing for the clothing line Joe Fresh.¹⁵⁹ After the Rana Plaza collapse, some companies including Disney withdrew from Bangladesh.¹⁶⁰

Activists want brands sold by Walmart and global clothing brands such as the Gap and Tommy Hilfiger to take responsibility for working conditions in the factories that produce their clothing.¹⁶¹ Human rights groups want retailers and apparel brands to sign the Bangladesh Fire and Building Safety Agreement,¹⁶² which establishes an independent system of factory inspectors whose recommendations are binding.¹⁶³ A 2013 implementation plan for the agreement led to incorporation of the Bangladesh Accord Foundation in October 2013 in the Netherlands.¹⁶⁴ There are six key components to the agreement:

¹⁵⁶ *Id.*

¹⁵⁷ Al-Mahmood & Banjo, *supra* note 148.

¹⁵⁸ Associated Press, *Death Toll in Bangladesh Passes 1,100*, N.Y. TIMES, May 11, 2013, <http://www.nytimes.com/2013/05/12/world/asia/death-toll-in-bangladesh-collapse.html>.

¹⁵⁹ Al-Mahmood & Banjo, *supra* note 148.

¹⁶⁰ Marc Gunther, *Gap Spearheads New Alliance for Bangladeshi Worker Safety*, THE GUARDIAN, July 11, 2013, <http://www.theguardian.com/sustainable-business/gap-alliance-bangladeshi-worker-safety>.

¹⁶¹ Bajaj, *supra* note 149.

¹⁶² ACCORD ON FIRE AND BUILDING SAFETY IN BANGLADESH, signed on May 15th 2013, *available at* <http://bangladeshaccord.org/>. “The Accord is an independent, legally binding agreement between brands and trade unions designed to work towards a safe and healthy Bangladeshi Ready-Made Garment Industry. Our purpose is to enable a working environment in which no worker needs to fear fires, building collapses, or other accidents that could be prevented with reasonable health and safety measures.” *Id.*

¹⁶³ Al-Mahmood & Banjo, *supra* note 148.

¹⁶⁴ *About the Accord*, ACCORD ON FIRE AND BUILDING SAFETY IN BANGLADESH, <http://bangladeshaccord.org/about/> (last accessed Aug. 14, 2015).

1. A five year legally binding agreement between brands and trade unions to ensure a safe working environment in the Bangladeshi RMG industry
2. An independent inspection program supported by brands in which workers and trade unions are involved
3. Public disclosure of all factories, inspection reports and corrective action plans (CAP)
4. A commitment by signatory brands to ensure sufficient funds are available for remediation and to maintain sourcing relationships
5. Democratically elected health and safety committees in all factories to identify and act on health and safety risks
6. Worker empowerment through an extensive training program, complaints mechanism and right to refuse unsafe work.¹⁶⁵

More than 200 apparel brands have signed, as well as importers and retailers from more than 20 European, North American, Asian and Australian retailers, eight Bangladesh trade unions, two global trade unions, and four NGO witnesses.¹⁶⁶ The Accord protects over 1600 factories and 2 million workers.¹⁶⁷

Wal-Mart did not sign the accord, but started paying for inspections of Bangladesh factories it uses and donated \$1.6 million for fire and workplace safety training.¹⁶⁸ Its website now features a global responsibility section setting forth responsible ethical sourcing¹⁶⁹ and supply chain safety standards,¹⁷⁰ and providing in-

¹⁶⁵ *Id.*

¹⁶⁶ *Signatories*, ACCORD ON FIRE AND BUILDING SAFETY IN BANGLADESH, <http://bangladeshaccord.org/about/> (last accessed Aug. 14, 2015).

¹⁶⁷ *Id.*

¹⁶⁸ Al-Mahmood & Banjo, *supra* note 148.

¹⁶⁹ *Sourcing Standards and Resources*, WALMART, <http://corporate.walmart.com/global-responsibility/ethical-sourcing/ethical-standards-resources> (last accessed Mar. 25, 2015).

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depth factory assessments¹⁷¹ and an annual report.¹⁷² Gap, Inc., also did not sign the accord, but reported that it had set aside \$20 million to improve Bangladesh factory safety.¹⁷³

In July 2013, nearly 20 retailers including Walmart and Gap,¹⁷⁴ and six North American retail associations announced their own five-year safety plan for garment factories in Bangladesh with inspection of all factories within a year, named Bangladesh Worker Safety Initiative.¹⁷⁵ Former U.S. Senators Olympia Snowe and George Mitchell acted as independent facilitators in its development and agreed to verify its effectiveness for at least the first two years.¹⁷⁶ It is to be implemented by an independent board chairman and an NGO.¹⁷⁷ Its purposes include developing safety standards, sharing results of inspections, and seeking factory support for democratic election of worker participation committees.¹⁷⁸ At the same time, a group of more than 70 mainly European retailers, including the world's two largest fashion retailers¹⁷⁹ announced a

¹⁷⁰ *Promoting Supply Chain Safety*, WALMART, <http://corporate.walmart.com/global-responsibility/ethical-sourcing/promoting-supply-chain-safety> (last accessed Mar. 25, 2015).

¹⁷¹ *In-Depth Factory Assessments*, WALMART, <http://corporate.walmart.com/global-responsibility/ethical-sourcing/in-depth-factory-assessments> (last accessed Mar. 25, 2015).

¹⁷² See GLOBAL COMPLIANCE PROGRAM REPORT ON FISCAL YEAR 2014, Walmart, <http://corporate.walmart.com/global-responsibility/global-compliance-program-report-on-fiscal-year-2014>.

¹⁷³ Al-Mahmood & Banjo, *supra* note 148.

¹⁷⁴ The 17 original members of the alliance included: “Canadian Tire Corp Ltd ; Carter’s Inc ; The Children’s Place Retail Stores Inc; Gap; Hudson’s Bay Co; IFG Corp; J.C. Penney Co Inc; Jones Group Inc; Kohl’s Corp; L. L. Bean Inc; Macy’s Inc; Nordstrom Inc; Public Clothing Co; Sears Holdings Corp; Target Corp; VF Corp; and Wal-Mart.” Jessica Wohl, *Walmart, Gap Announce Bangladesh Factory Safety Plan with Other North American Retailers*, HUFFINGTON POST, July 10, 2013, 10:23 AM, http://www.huffingtonpost.com/2013/07/10/bangladesh-factory-safety-plan-walmart_n_3573209.html.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ The world’s two largest fashion retailers were Inditex SA, owner of the Zara chain, and H&M. *Id.*

separate safety plan with coordinated inspections and published results.¹⁸⁰

Bangladesh acceded to the ICESCR in 1998.¹⁸¹ Accordingly, as explained above, Bangladesh is responsible under article 2(1) “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.”¹⁸² Article 12(2)(b) of the ICESCR, the right to healthy natural and workplace environments, requires, *inter alia*, prevention of occupational accidents and industrial hygiene to prevent working-environment health hazards.¹⁸³

Bangladesh individually could not enforce its building code because it lacked money and expertise.¹⁸⁴ Less than half of the 14,000 Bangladesh factories were authorized.¹⁸⁵ Perhaps more important is that factory owners obstructed reform with their political clout.¹⁸⁶ “[T]he Bangladeshi government . . . had no more success in cracking down on garment factories than the US government has had in strictly regulating Wall Street.”¹⁸⁷

Following the 2012 and 2013 incidents, the International Labor Organization (ILO) stepped in and facilitated what became the National Tripartite Plan of Action on Fire Safety and Structural Integrity in the Ready-Made Garment Sector in Bangladesh, an agreement between Bangladeshi entities that does not include

¹⁸⁰ HUMAN RIGHTS WATCH, *Bangladesh*, WORLD REPORT 2014, <http://www.hrw.org/world-report/2014/country-chapters/bangladesh?page=3>.

¹⁸¹ U.N. TREATY COLLECTION, *Human Rights*, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Aug. 19, 2015).

¹⁸² *See* ICESCR, *supra* note 8, at art. 12(2)(b).

¹⁸³ *General Comment No. 14*, *supra* note 17, ¶ 15.

¹⁸⁴ Gunther, *supra* note 160.

¹⁸⁵ *See id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

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retailers.¹⁸⁸ It was signed by the leading garment industry trade associations and the Bangladesh Ministry of Labor and Employment, with the goal of improving worker safety through the tripartite legislative, administrative and practical paths.¹⁸⁹ Bangladesh allocated 3 million dollars to overhaul the administrative agencies charged with monitoring and bring the number of inspectors up to 800.¹⁹⁰ Inspectors will use uniform criteria developed in collaboration with the ILO and the Accord, and planned to inspect all garment factories by December 2014.¹⁹¹ Bangladesh and the ILO pledged \$ 24.21 million and other countries are contributing: \$15 million in initial contributions came from the Netherlands and the United Kingdom,¹⁹² both signatories of the ICESCR.¹⁹³

D. Genetically Engineered Crops Pose Promises and Dangers

Genetically modified (GM) foods are in the news these days, often linked with GM-food producer Monsanto. Genetic engineering of foods selectively inserts genes into plants to breed into them specific advantages, such as resistance to disease, pests, drought and salinity; increased nutrient uptake to reduce need for fertilizer; herbicide tolerance to allow spraying to kill weeds but not plants; early maturity; longer shelf life; and health-protective properties such as increased content of nutrients,¹⁹⁴ for example Golden Rice.¹⁹⁵

¹⁸⁸ Benjamin A. Evans, *Accord on Fire and Building Safety in Bangladesh: An International Response to Bangladesh Labor Conditions*, 40 N.C. J. INT'L L. & COM. REG. 597, 612 (2015).

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 613.

¹⁹¹ *Id.* at 615.

¹⁹² *Id.* at 614-15.

¹⁹³ *Status of Ratification Interactive Dashboard*, *supra* note 10 (ICESCR).

¹⁹⁴ See Hossein Azadi & Peter Ho, *Genetically Modified and Organic Crops in Developing Countries: A Review of Options for Food Security*, 28 BIOTECHNOLOGY ADVANCES 161, 164, 166 (2010); Keith Aoki, *Food Forethought: Intergenerational Equity and Global Food Supply – Past, Present, and Future*, 2011 WIS. L. REV. 399, 457-8 (2011).

¹⁹⁵ Aoki, *supra* note 194, at 458 (2011) (citing Xudong Ye et al., *Engineering the Provitamin A (β-Carotene) Biosynthetic Pathway into (Carotenoid-Free) Rice*

However, GM poses not only the promise of better health through increased food supply and protective properties,¹⁹⁶ but the danger of side effects including allergenicity, toxicity, carcinogenicity, and altered nutritional quality.¹⁹⁷ Additionally, genetic engineers link transgenes to antibiotic-resistant genes before inserting them. They then apply an antibiotic to reveal which plants have been successfully transformed; a human health hazard could result with human consumption of antibiotic-resistant crops.¹⁹⁸ The effect could be multiplied because transgenes easily escape from GM crop fields into natural plant populations; critics also warn that transgene introgression results in destruction of biodiversity.¹⁹⁹

Monsanto claims that GM food is safe; it responds:

The World Health Organization, the American Medical Association, the U.S. National Academy of Sciences, the British Royal Society, among others that have examined the evidence, all come to the same conclusion: consuming foods containing ingredients derived from GM crops is safe to eat and no riskier than consuming the same foods containing ingredients from crop plants modified by conventional plant improvement techniques (i.e. plant breeding).²⁰⁰

Critics also express environmental concerns.²⁰¹ Transgenes easily escape from GM crop fields into natural plant populations, which results in destruction of biodiversity.²⁰² Scientists are working

Endosperm, 287 *SCIENCE* 303, 303 (2000)).

¹⁹⁶ See Azadi & Ho, *supra* note 194, at 160, 161, 165.

¹⁹⁷ See *id.* at 162.

¹⁹⁸ Aoki, *supra* note 195, at 460.

¹⁹⁹ *Id.* at 458-60 (2011) (pollen and ovules from GE crops introgresses into surrounding plant populations, introducing pesticide- and herbicide-resistance that can create “super-weeds,” as well as disrupting ecodynamics by domination of some plants at others’ expense).

²⁰⁰ *Commonly Asked Questions about the Food Safety of GMOs*, MONSANTO, <http://www.monsanto.com/newsviews/pages/food-safety.aspx> (last visited May 11, 2015).

²⁰¹ See Azadi & Ho, *Genetically Modified*, *supra* note 196, at 192.

²⁰² Aoki, *supra* note 195, at 458 (pollen and ovules from GE crops

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on technological solutions, such as alternative marker genes to replace the antibiotic-resistant markers, restricting transgenes to male-sterile lines to reduce gene introgression through pollen, and plants that self-excise selection markers and transgenes themselves from pollen so dispersed pollen is transgene-free.²⁰³

The right to health is at the center of the GM-crop controversy. GM crops could be the answer to world hunger by facilitating production of greater supplies of food with better nutrition, health-protective properties, and longer shelf life. On the other hand, GM crops could have environmental and detrimental long-term human health effects.

*E. Patents Prevent Affordable Access to Essential Medicines;
Millions Die*

A subject in the news that may more readily bring to mind the right to health is the more than six million people who die every year from HIV/AIDS, tuberculosis, and malaria.²⁰⁴ That number is increasing, especially in developing countries²⁰⁵ where they lack access to essential medications that can save or prolong their lives.²⁰⁶ In Botswana, 38.8% of adults were infected with HIV in 2001, 33.7% in Zimbabwe, and a 15-year-old Southern African child's chance of dying of HIV/AIDS were between 1 in 3 and 1 in 2 in a world where there is effective therapy.²⁰⁷ About 600 people died from AIDS every day in South Africa in 1999.²⁰⁸

One reason victims could not get access to these medications

introgresses into surrounding plant populations, introducing pesticide- and herbicide-resistance that can create "super-weeds," as well as disrupting ecodynamics by domination of some plants at others' expense).

²⁰³ *Id.* at 460-61.

²⁰⁴ *HIV/AIDS, Tuberculosis and Malaria*, 1 HTM CLUSTER 1 (2004), <http://www.who.int/3by5/en/newsletterHTM.pdf>.

²⁰⁵ *Id.*

²⁰⁶ Yamin, *supra* note 22, at 325, 326.

²⁰⁷ *Id.* at 369.

²⁰⁸ Stacey B. Lee, *Can Incentives to Generic Manufacturers Save the Doha Declaration's Paragraph 6?*, 44 *GEO. J. INT'L L.* 1387, 1388 (2013).

is that pharmaceutical companies with patents on them refused to allow manufacture of inexpensive generic versions. A decade ago, only one in a thousand AIDS/HIV victims could get treatment because pharmaceutical companies held patents on the needed antiretroviral drugs and priced them at \$10,000-15,000 per patient per year.²⁰⁹ The World Trade Organization's 1994 Trade-Related Aspects of Intellectual Property Rights Agreement established comprehensive global standards to protect intellectual property, which included a minimum 20-year protection on pharmaceutical products.²¹⁰ Before TRIPS, most developing countries provided no patent protections for pharmaceuticals.²¹¹

TRIPS includes flexibilities to address member countries' inability to obtain generic medicines because of pharmaceutical patents.²¹² A "compulsory licensing" mechanism permits a government or authorized third party to produce a patented medicine without the right-holder's permission.²¹³ A developing country's government may legally suppress a patent to make medicines affordable in that country²¹⁴ under certain conditions: (1) the government should try to negotiate a voluntary license on reasonable terms, except in a national emergency, (2) the government must remunerate the patent holder adequately, and (3) the license must be "predominantly for the supply of the domestic market."²¹⁵ Other conditions are that (1) the government must limit the license's scope and duration to the authorization's purpose, (2) the license is nontransferable and nonexclusive, (3) the license ends when the circumstances end and are not likely to recur, and (4) the

²⁰⁹ Ellen 't Hoen, Jonathan Burger, Alexandra Calmy & Suerie Moon, *Driving a Decade of Change: HIV/AIDS, Patents, and Access to Medicines for All*, 14 J. INT'L AIDS SOC'Y 15 (2011).

²¹⁰ Agreement on Trade-Related Aspects of Intellectual Property Rights arts. 28, 33, Apr. 15, 1994, 1869 U.N.T.S. 299 (1994) [hereinafter TRIPS]; Lee, *supra* note 208, at 1387, 1388.

²¹¹ Lee, *supra* note 208, at 1391.

²¹² *Id.* at 1388.

²¹³ TRIPS, *supra* note 210 art. 31(b).

²¹⁴ *Id.* art. 31(f); Lee, *supra* note 208, at 1387, 1395.

²¹⁵ Donald Harris, *TRIPS After 15 Years: Success or Failure, as Measured by Compulsory Licensing*, 18 J. INTELL. PROP. L. 367, 383 (2011).

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government's decision can be judicially reviewed.²¹⁶

ICESCR article 12(2)(c), the right to prevention, treatment and control of diseases and (2)(d) the right to health facilities, goods and services include "the provision of essential drugs."²¹⁷ States that have ratified the ICESCR or other treaties that include the right to health bear the three-pronged obligations to respect, protect, and fulfill the right to health:

- (1) to refrain from taking actions or enacting laws that would restrict the availability or accessibility of medications;
- (2) to protect the public's access to medications from threats imposed by third parties, including pharmaceutical companies; and
- (3) to take deliberate steps to move toward the progressive realization of access to medications on a non-discriminatory basis.²¹⁸

While South Africa did not ratify the ICESCR until 2015,²¹⁹ its 1966 South African Constitution established a right to health care within budgetary constraints.²²⁰ In 1997, the South African Parliament passed the Medicines and Related Substances Control Amendment Act,²²¹ which provided for compulsory licensing, to allow South Africa to produce its own affordable AIDS medicines, and for imports of low-priced drugs from third parties without patent-holder authorization, allowing more victims to obtain life-

²¹⁶ TRIPS, *supra* note 210 art. 31(c), (f), (k), (l).

²¹⁷ *General Comment No. 14*, *supra* note 17, ¶¶ 16, 17.

²¹⁸ Yamin, *supra* note 22, at 369.

²¹⁹ See *Status of Ratification Interactive Dashboard*, *supra* note 10 (ICESCR: South Africa).

²²⁰ Patrick Bond, *Globalization, Pharmaceutical Pricing, and South African Health Policy: Managing Confrontation with U.S. Firms And Politicians*, 29(4) INT'L J. HEALTH SERVS. 765, 767 (1999), available at <http://joh.sagepub.com/content/29/4/765.long>.

²²¹ Medicines and Related Substances Control Amendment Act 101 of 1996 (S. Afr.), available at http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/medicines_and_related_sub_act_101_of_1965.pdf.

saving drugs.²²² Although, as stated above, TRIPS allows compulsory licenses in health emergency situations, pharmaceutical manufacturers sued the South African government challenging the law as infringing on patents.²²³ Drug manufacturers pressured the United States government to stop South Africa from producing its own generic medicines, and the U.S., led by Vice President Al Gore, launched a campaign against South Africa, threatening sanctions and enlisting other countries to join in the campaign.²²⁴ International outcry eventually resulted in the U.S. backing down.²²⁵ The pharmaceutical companies dropped their suit.²²⁶

South Africa returned to the forefront of litigation over access to essential medicines in 2002 in *Minister of Health v. Treatment Action Campaign*, which considered whether South Africa was meeting its burden of proof in showing it had adopted all reasonable measures to ensure universal access to essential medications.²²⁷ The Constitutional Court held that South Africa could not reasonably limit the availability of Nevirapine, a drug used to prevent transmission of HIV/AIDS from pregnant women to their babies, to 18 pilot sites.²²⁸ It affirmed the judiciary's authority to oblige the executive branch to adopt policies and implement programs that require social spending.²²⁹

Right-to-health issues related to access to HIV/AIDS medicines, with an obvious connection to the right to life, are

²²² *Id.* § 15(C), 15(C)(b).

²²³ Bond, *supra* note 220, at 766.

²²⁴ *See id.* at 769-87.

²²⁵ Lee, *supra* note 208, at 1397.

²²⁶ Ann M. Simmons, *Suit Against Cheap AIDS Drugs Ends in S. Africa*, L.A. TIMES, Apr. 20, 2001, <http://articles.latimes.com/2001/apr/20/news/mn-53295;SouthAfrica,U.S.EndFightOverAIDSDrugs:AvailabilityandCostofPatent-ProtectedMedicinesatIssue>, BALTIMORE SUN, Sept. 19, 1999, http://articles.baltimoresun.com/1999-09-19/news/9909190189_1_south-africa-aids-in-africa-aids-drugs.

²²⁷ *See Minister of Health v. Treatment Action Campaign* 2002 (5) SA 721 (CC) at 57 para. 100 (S. Afr.), available at http://www.lib.utoronto.ca/diana/TAC_case_study/ministerofhealthvtacconst.court.pdf.

²²⁸ *Id.* at 75-76, para. 135(3).

²²⁹ *See id.* at 26, para. 38.

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increasingly considered to be justiciable in national courts.²³⁰ Colombia's Constitutional Court has set forth an instructive test for the justiciability of the right to health services: first, the health-related issue must implicate other "fundamental" rights such as life, education, or work; second, the state's failure to provide health services must present a "grave and imminent threat to human life or health"; third, the complainant must be in extreme financial as well as physical need of services; and fourth, the state must have the resources to provide services in the particular case.²³¹

These five examples—air pollution, transboundary dumping of toxic wastes, outsourcing of manufacturing to developing countries, genetically modified seeds, and lack of access to essential medicines—illustrate on a global level the ubiquity and complexity of issues that implicate the human right to health and demonstrate its interdependence with other human rights.

Conclusion

Even though the right to health, like other human rights, is not legally enforceable in all parts of the globe, public awareness of human rights has become practically universal since the Universal Declaration of Human Rights introduced the concept in 1948. As stated above, the number of states that are parties to human rights treaties and that enact domestic human rights laws continues to grow, as does the network of nongovernmental organizations and movements. All of those components are important. The more the right to health is perceived as normative, the more likely it becomes that States will feel obligated to implement health protections, with or without any legally enforceable requirement to do so. Additionally, the right to health is interdependent with so many other human rights—such as the rights to life, food, housing, safety, standard of living, education and development—that increasing

²³⁰ Yamin, *supra* note 22, at 341.

²³¹ See Corte Constitucional [C.C.], 1999, Sentencia SU.819/99, Alejandro Moreno Alvarez v. Estado Colombiano, *available at* <http://www.corteconstitucional.gov.co/relatoria/1999/SU819-99.htm>.

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protections in those areas also protect the right to health. Kofi Annan's aspiration that health be a right to fight for rather than a mere wish is coming true, and the global community is indeed progressing toward realizing the human right to health.