Integrating a Human Rights-Based Approach to Development and the Right to Development into Global Governance for Health

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SUMMARY

This chapter proposes a human rights framework for global economic governance and specifically for the economic and financial sources of support to health systems in the form of: a) general principles of human right-based development—as defined primarily in inter-agency guidance and training—and b) the right to development – as defined in the 1986 Declaration on the Right to Development and further elaborated by various mandates reporting to the UN Human Rights Council (HRC). No institution of development financing was initially inspired by or currently has as its principal vision a rights-based approach to development or the right to development. Nevertheless, each has—in different ways—been attentive to human rights norms and principles. After first examining the general principles of human rights-based development in Part I, Part II explores the emergence and current state of the right to development, focusing on its public health dimensions. The chapter concludes by addressing obstacles to the incorporation of human rights in health funding strategies.

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I. General Principles of Human Rights-Based Development

Rights-based development as applied to health governance engages three intersecting understandings of human wellbeing:

1. Public health concentrates on the requirements of wellbeing defined in terms of physical, mental, and social dimensions of human existence;
2. Development tends to focus on wellbeing, defined in terms of the economic processes that improve people’s material conditions; and
3. Human rights tends to deal with wellbeing in terms of normative constraints on power relations to ensure human dignity and the elimination of repressive and oppressive processes.

Thus, while public health, development, and human rights have “human wellbeing” in common—or, as philosophers would say, “flourishing,” or the “good life”—each approaches this meta-goal through different frameworks — physical, mental, and social wellbeing; economic processes; and normative constraints, respectively.

The role of international actors with respect to human rights, public health, and human development may be explored in both (a) the theory through which human rights thinking is applied to development and (b) the practice of international actors to incorporate human rights in more technocratic approaches to health and development.

A. Human Rights-Based Approaches to Health and Development in Theory

Building on the abstract definitions above, it is possible to provide a more complete picture of how public health, development, and human rights are related by examining two theoretical approaches to understanding these interconnections: (1) the social justice approach and (2) the capabilities approach.

1. The Social Justice Approach

Advancing social justice by eliminating social disparities and inequalities in access to health is widely regarded as fundamental to the field of public health, defining social justice as “fair and equitable treatment of people” (Ruger 2004, 1075). The social justice approach is illustrated by a focus on inequalities, fair processes (Daniels 2005; Daniels et al. 2000; Daniels et al. 2005), and social epidemiology (Krieger 2000, 2001), in addition to the extensive research on health equity (Global Equity Gauge Alliance 2003). These studies base the concept of health equity on theories of social justice and draw attention to the failure to improve overall health status in terms of decline in mortality and morbidity to reach some social groups, denying them equality of opportunity (Sen 2004).

Social justice thereby captures an important feature of the human rights framework for development — the emphasis on a moral imperative for eliminating glaring social inequality within societies and structurally-imbedded patterns of international support for those inequalities (Kim et al. 2000). However, the human rights framework goes beyond a commitment to social justice in that it supports other dimensions of a life people value,
dimensions that are not focused exclusively on reducing the suffering of the poor and vulnerable. It is also different from social justice insofar as it does not rely on a subjective sense of outrage at the suffering of the poor and excluded within society—however admirable such sentiments may be—but rather on a set of agreed standards that define what governments must do to redress social injustice.

Within the institutions of global health governance, it is sometimes easier to draw on the concept of social justice rather than on human rights to define the moral basis of setting priorities in health. The World Health Organization (WHO) uses the terms “human rights” and “social justice” in different ways. WHO’s 12th General Programme of Work, adopted by the World Health Assembly “as the basis for strategic planning, monitoring and evaluation of WHO’s work during the period 2014–2019” (WHA 2013), considers human rights as an “added dimension” among other “wider concerns” while the “the principle of equity and social justice” is one of the “key elements” of WHO’s approach, according to which “WHO will continue to give emphasis where needs are greatest” (WHO 2014, 19). Thus, social justice provides a moral framework which is commonly used in the context of global health governance—as exemplified by WHO’s 12th General Programme of Work—whereas human rights has a more marginal status, at least in the context of global health governance, even though it is seen as central to the rights-based approach to development.

2. The Capabilities Approach

At the abstract level, the meta-goals of public health, development, and human rights have also been analyzed in terms of “human capabilities.” (Nussbaum 1988; Nussbaum 1993) Nobel Prize-winning economist Amartya Sen has articulated an approach to human rights and development that is widely endorsed by United Nations (UN) institutions and is of particular relevance to health. In Development as Freedom, Sen devotes a chapter to “Poverty as Capability Deprivation,” in which he argues that development is not the acquisition of more goods and services, but the enhanced freedom to choose, to lead the kind of life one values (Sen 1998). These enhanced choices are called “capabilities” (Crocker 1992). Poverty, Sen explains, is the deprivation of basic capabilities. He examines three features of deprivation of basic capability—premature mortality, undernourishment, and illiteracy— which have come to be the basis for the Human Development Index of UN Development Programme (UNDP). In the capabilities discourse, “capability” is the option available to the individual to partake of some valued dimension of life; “functioning” is the exercise of that option (Sen 1999).

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1 In the early 2000s, WHO seemed to see human rights as more directly relevant to health governance. In a joint publication with the Office of the High Commissioner for Human Rights (OHCHR), WHO claimed that it worked to “strengthen the capacity of WHO and its member States to integrate a human rights-based approach to health; advance the right to health in international law and international development processes; and advocate for health-related human rights” and included seven priority areas in its 11th General Programme of Work (2006–2015), including “promoting universal coverage, gender equality and health-related human rights” (OHCHR 2008, 29).
The application of capability emerges in development theory by incorporating a range of concepts designed to shift the focus from economic growth to human welfare, and drawing on Sen’s earlier writing on rational choice and commodities (Sen 1985, 2005). Sen and Sudhir Anand provided a background paper for UNDP’s Human Development Report 1990, in which they argued that “the central issue” was “the need for universalist attention in valuing the enhancement of human capabilities, as opposed to partisan interest in promoting aggregate growth” (Anand and Sen 1994, 16). Human development, as compared with economic growth, “directly enhances the capability of people to lead worthwhile lives” (Ibid., 34).

From the beginning of this theoretical discussion, human rights was explicitly part of thinking about human development under a capability approach. For example, UNDP established a policy in 1998 of integrating human rights into its approach to sustainable human development (UNDP 1998) and drew on these ideas in devoting the Human Development Report 2000 to human rights. As the Human Development Report 2001 explained,

...human development shares a common vision with human rights. The goal is human freedom. And in pursuing capabilities and realizing rights, this freedom is vital. People must be free to exercise their choices and to participate in decision-making that affects their lives. Human development and human rights are mutually reinforcing, helping to secure the well-being and dignity of all people, building self-respect and the respect of others (UNDP 2001, 9).

Martha Nussbaum has been even more forceful in relating capabilities to human rights, noting that capabilities:

include many of the entitlements that are also stressed in the human rights movement: political liberties, the freedom of association, the free choice of occupation, and a variety of economic and social rights. And capabilities, like human rights, supply a moral and humanly rich set of goals for development... Thus capabilities have a very close relationship to human rights, as understood in contemporary international discussions (Nussbaum 2003, 36; Nussbaum 1999).

Nussbaum views health as central to capabilities, exemplified by the first three capabilities of her “explicit list”:

1. Life. Not dying prematurely, or before one’s life is so reduced as to be not worth living.
2. Bodily Health. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
3. Bodily Integrity. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction (Nussbaum 2003, 41).

Jennifer Ruger applies this capabilities approach to health to the practice of global health institutions, arguing that these institutions
have important roles in the implementation of a capability approach to health because they can help generate and disseminate the knowledge and information required to reduce health disparities and can also empower individuals and groups in national and global forums. Indirectly, they can push for greater citizen participation in health-related decision-making in developing countries, both within (eg, in determining resource allocation) and outside the health sector (Ruger 2004, 1079).

She adds that global health institutions can also “give individuals and groups a greater voice in national and international forums and programmes” and, reflective of the chapters in this volume, “provide technical assistance, financial aid, and global advocacy to support the development of equitable and efficient health systems and public health programmes” (Ibid.).

In addition to these positive impacts that the capabilities approach can have on global health institutions, Ruger has systematically explored the capabilities approach to the right to health (Ruger 2006). In her analysis, capabilities are clarified by reference to “provincial globalism,” a theory of global health justice that involves nine principles or features, including capabilities and global governance. Regarding capabilities, she explains that provincial globalism “holds health capabilities and more specifically central health capabilities—freedom from avoidable morbidity and premature death—as morally salient human interests in their own right and as preconditions or prerequisites for other capabilities” (Ruger 2012, 37). Regarding global health governance, her theory of provincial globalism “elaborates a multilevel governance system in which all actors have respective roles and responsibilities based on functions and needs and voluntary commitments” (Ibid., 41). Provincial globalism thus becomes “a theory of global health justice that meshes with the theory of shared health governance” (Ibid., 42), providing a basis for understanding how global health governance fits into international relations theory.

These recent efforts to expand the theoretical understanding of capability reinforce the trend of international institutions, especially UNDP, to introduce the capability approach into development practice. The grounding of this approach in development economics—and its linkages to human rights—make it the most appealing theoretical framework to move from theory to practice under a human rights-based approach to health and development.

B. Human Rights-Based Approaches to Health and Development in Practice

Human rights-based approaches to development affirm that human rights must be integrated into sustainable human development as a matter of policy. This “human rights approach to development assistance” seeks to apply human rights principles as a comprehensive guide for appropriate official development assistance, for the manner in which it should be delivered, for the priorities that it should address, for the obligations of both donor and recipient governments and for the way that official development assistance is evaluated (HRCA 1995).

Advanced by NGO advocates (Häusermann 1998), the human rights-based
approach has become policy of the principal human rights agency of the UN and has been adopted by the UN agencies responsible for health and development (UNDG 2003). It has also been endorsed by regional development agencies, such as OECD, which in February 2007 adopted its “Action-Oriented Policy Paper on Human Rights and Development” (OECD-DAC 2007). As addressed in chapter 18, bilateral aid institutions (such as USAID, DFID, SIDA, CIDA, DANIDA) now often have explicit human rights policies which may influence their financial assistance. This human right-based approach stands in marked contrast to traditional approaches to economic development (focusing on growth in GDP) and provides direct implications for global health governance, especially under the 2030 Agenda for Sustainable Development.

1. Human Rights Policies of International Agencies Affecting Health Governance

In recent years, the UN system has sought, as reviewed in chapter 3, to translate the commitment to human rights in development into a system-wide reform process called the “Human Rights Mainstreaming Mechanism” by the UN Development Group (UNDG) or “the human rights based approach” (HRBA) to development. Echoing ideas expressed by then UN Secretary-General Kofi Annan, the World Conference on Human Rights, in its 1993 Vienna Declaration and Programme of Action, stated that “[t]he existence of widespread extreme poverty inhibits the full and effective enjoyment of human rights; its immediate alleviation and eventual elimination must remain a high priority for the international community” (World Conference on Human Rights 1993, para. 14). The following year, the Secretary-General issued his Agenda for Development, which alluded to the Vienna Declaration’s affirmation of the “mutually reinforcing interrelationship of democracy, development and respect for human rights” and focused more on the importance of democracy and good governance as essential for development (UN General Assembly 1994, paras. 119–120). The momentum for human rights mainstreaming accelerated in 1997, when Secretary-General Annan stated that among the priority areas for the reform, he proposed “[e]xtending human rights activities by reorganizing and restructuring the human rights secretariat and the integration of human rights into all principal United Nations activities and programmes” (UN General Assembly 1997, para. 78). Cutting across the UN system, human rights mainstreaming would be pursued principally through the UN’s development agenda.

Responding to this call across UN agencies, an inter-agency workshop adopted in 2003 a “Common Understanding on Human Rights-Based Approaches to Development” (UNDG 2003). The following year, twenty-one heads of UN departments and agencies adopted the Action 2 Plan of Action, which: was fully operational from 2006 to 2009, supported more than sixty UN country teams, introduced HRBA in training of staff, and created an “HRBA Practitioners’ Portal on Human Rights Based Approaches to Programming” (OHCHR 2007).

2 Recently (June 2017) the UN Staff College offered a course on “Human Rights-Based Approach to Development Programming,” which aims to build “capacity to integrate human rights into all policy and programming processes within the context of the new 2030 Agenda for Sustainable Development.”
The Office of the High Commissioner for Human Rights (OHCHR) now supports UN departments and agencies in implementing the “rights-based approach to development,” which it defines as “a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights” (OHCHR 2006, 15). This OHCHR approach builds on Secretary-General Annan’s view in 1998 that:

The rights-based approach to development describes situations not simply in terms of human needs, or of development requirements, but in terms of society’s obligations to respond to the inalienable rights of individuals. It empowers people to demand justice as a right, not as charity, and gives communities a moral basis from which to claim international assistance where needed (UN General Assembly 1998).

Extending these views in 2005, Annan concluded that “[w]e will not enjoy development without security, we will not enjoy security without development, and we will not enjoy either without respect for human rights” (UN General Assembly 2005, para. 17). These positions have guided the system-wide work of OHCHR to implement a human right-based approach to development.

2. Human Rights in the 2030 Development Agenda

Since 2000, a parallel terrain for policy discussion on the relationship between economic and human rights approaches to health governance has been the Millennium Development Goals (MDGs) (2000-2015) and the Sustainable Development Goals (SDGs) (2015-2030). After more than a decade of tension between the technocratic approach of officials promoting the MDGs and the normative approach of human rights advocates (Alston 2005; Darrow 2012), the post-2015 development agenda was adopted in the form of a resolution entitled “Transforming our world: the 2030 Agenda for Sustainable Development,” enumerating seventeen SDGs and 169 targets (UN General Assembly 2015). From the human rights perspective, the 2030 Agenda represents an advance over the MDGs, beginning with the affirmation in the preamble that the SDGs “seek to build on the Millennium Development Goals and complete what they did not achieve. They seek to realize the human rights of all” (Ibid., preamble). The declaration contains several strong paragraphs affirming the importance of human rights in the post-2015 development agenda, as well as this strong paragraph on health:

3 Part of the earlier impetus for this commitment is General Assembly resolution 48/141 of 1993, which called on the UN High Commissioner for Human Rights, as discussed in chapter 21, to “[r]ecognize the importance of promoting a balanced and sustainable development for all people…” (UN General Assembly 1993, para. 3).
To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development (Ibid., para. 26).

The High Level Political Forum on Sustainable Development (HLPF) will monitor the implementation of the SDGs. Indicators have been prepared by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) and agreed upon by the UN Statistical Commission (ECOSOC 2016). Of particular value for achieving the vision of health in the paragraph quoted above is SDG 3, which seeks to “[e]nsure healthy lives and promote well-being for all at all ages,” with related targets and indicators, including on access to affordable essential medicines and vaccines (Ibid., 19). However, beyond the general affirmation that the SDGs “seek to realize the human rights of all” (UN General Assembly 2015, preamble), only a few of the indicators refer to human rights, including those on reproductive rights under SDG 5, labor rights under SDG 8, anti-discrimination in SDG 10 and access to justice in SDG 16 (ECOSOC 2016).

II. The Right to Development

Rather than affirming that development must be pursued with due attention to human rights (the rights-based approach model), the right to development seeks to establish a right of peoples and individuals both to achieve sustainable human development and to benefit from human rights in development. The idea of a human right to development was not originally part of the catalogue of human rights in the post-war Universal Declaration of Human Rights or the international covenants, although it can trace its normative content to numerous principles of international cooperation reaffirmed in UN documents since World War II (UN 1990). The first effort to formulate a distinct right was made in a 1972 lecture by Senegalese Judge Kéba M’Baye (M’Baye 1972). Five years later, with Senegal as chair, the UN Commission on Human Rights (succeeded in 2006 by the Human Rights Council) requested a study on “the international dimensions of the right to development as a human right in relation with other human rights based on international cooperation, including the right to peace, taking into account the requirements of the New International Economic Order and fundamental human needs” (Commission on Human Rights 1977). Pursuant to that request, the UN Secretariat produced a 161-page study, conceptualizing a
right to development and recognizing the major challenges to this right, including the difficulties in translating the concept of a right to development “into a notion capable of providing practical guidance and inspiration, based on international human rights standards, in the context of development activities” (ECOSOC 1979, para. 315).

When the Commission on Human Rights began formulating the right to development (Commission on Human Rights 1981), the political climate had become highly charged with ideological positioning on practically every issue. Frustrated with the Cold War rivalry dominating international relations, developing countries, functioning through the Non-Aligned Movement (NAM), supported Senegal’s initiative to have the UN declare development a human right and a normative basis for the establishment of a New International Economic Order (NIEO) (OHCHR 2013). Their intention was to use the declaration on the right to development to oblige those countries that dominated the international economy to accept what they had not accepted in the NIEO – greater responsibility to eliminate the structural causes of poverty, larger payments for raw materials extracted from developing countries, additional aid, and improvements to the terms of trade in favor of developing countries (Salomon 2010).

Under pressure from North American and European delegations, however, the Commission’s drafting committee agreed in 1981 that, while a general moral commitment to development was acceptable, the text would neither affirm any legal obligation to transfer resources from North to South nor codify any specific obligations regarding any of the issues contained in the declaration (Marks 2004).

The UN Declaration on the Right to Development was finally proclaimed by the UN General Assembly in December 1986 (UN General Assembly 1986). As a resolution of the General Assembly, the Declaration does not create any legal obligations, although it carries moral and political authority (Marks 2010). It was a compromise document of sixteen preambular paragraphs and ten articles setting out: a core definition of development; an enumeration of rights and duties of individuals and states; a commitment to the elimination of massive human rights violations and to international peace and security; a reiteration of the principles of non-discrimination, interrelatedness of rights, and participation; and an enumeration of steps states should take at the national and international levels to realize this right.

Since the adoption of the Declaration, the idea of an internationally recognized human right to development has remained contested. The North-South tension regarding the use of human rights institutions to restrain the dominant economic powers, and especially to impose any legal obligations, continues today, and debate on the issue in international fora has even been described by the UN High Commissioner for Human Rights as “political theatre” (OHCHR 2013, iii). In order to examine this right from the perspective of global economic governance and global health funding agencies, it is necessary to a) review how the clarification of the right to development has addressed global health funding and b) analyze the potential of the right to development to guide global governance.

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4 States adopted the Declaration by a vote of 146 in favor, one against (United States), and eight abstentions (Denmark, Finland, the Federal Republic of Germany, Iceland, Israel, Japan, Sweden, and the United Kingdom).
A. Health Governance in the Work of the High-Level Task Force

In addition to adopting annual resolutions stressing the importance of a right to development, the Commission on Human Rights in the 1980s and 1990s set up several working groups on the implementation of the right to development. While they did not initially accomplish much in the way of practical guidance to influence development policy and action, a breakthrough occurred in 1998, with the Commission recommending the establishment of a follow-up mechanism that would consist of an open-ended working group (OEWG) of all governments and an Independent Expert on the right to development (Commission on Human Rights 1998). The mandate of the Independent Expert was “to present to the working group at each of its sessions a study on the current state of progress in the implementation of the right to development as a basis for a focused discussion, taking into account, inter alia, the deliberations and suggestions of the working group” (Commission on Human Rights 1998, para. 10).

Dr. Arjun K. Sengupta, a prominent Indian economist, was appointed Independent Expert in 2000, and by 2004, had produced eight reports. He went on to be the Independent Expert on Human Rights and Extreme Poverty and then was elected to chair the OEWG until his passing in 2010. Sengupta brought a fresh approach to understanding the right to development, which he defined as “the right to a process that expands the capabilities or freedom of individuals to improve their well-being and to realize what they value” (Commission on Human Rights 2000, para. 22). In 2004, the Commission established the high-level task force on the implementation of the right to development (the Task Force) to assist the OEWG, providing the necessary expertise to enable the OEWG to make appropriate recommendations (Commission on Human Rights 2004a). As chair of the OEWG, Sengupta worked with the Task Force as it carried out its mandate, first to look at the implementation of the MDGs, social impact assessments, and best practices in the implementation of the right to development (Commission on Human Rights 2004b) and then, from 2005 to 2010, to focus on MDG 8 (global partnership for development), proposing right to development criteria for the periodic evaluation of global partnerships (Commission on Human Rights 2005b).

In 2006, the OEWG adopted the Task Force’s right to development criteria—including seven relating to “structure/enabling environment,” five relating to “process,” and three relating to “outcome” (HRC 2007a)—and requested the Task Force to apply them to selected partnerships. The Task Force applied these criteria from 2007 to 2009 to ten partnerships for development, three of which were directly related to global health governance, namely (1) the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property; (2) the Special Programme for Research and Training in Tropical Diseases; and (3) The Global Fund to Fight AIDS, Tuberculosis and Malaria.5

5 The other partnerships assessed by the task force were: the New Partnership for Africa’s Development (NEPAD); The Paris Declaration on Aid Effectiveness; the African Peer Review Mechanism (APRM); the Cotonou Agreement between the European Union and African, Caribbean and Pacific (ACP) countries; Debt relief provided by the Heavily Indebted Poor Countries Initiative and the Multilateral Debt Relief Initiative; the Development Agenda of the World Intellectual Property Organization (WIPO); and the Clean Development Mechanism (CDM) under the Kyoto Protocol to the UN Framework Convention on Climate Change. (HRC 2010a, paras. 20-62)
1. Intergovernmental Working Group on Public Health, Innovation and Intellectual Property

The Task Force reviewed the creation of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property by the World Health Assembly in 2006 and the adoption of the WHO Strategy and Plan of Action in 2008 (WHA 2008). The Task Force was attentive to the fact that the Strategy and Plan of Action not only sought to facilitate access to essential medicines among the poor and promote innovation in health products and medical devices, but also that the incentive schemes aimed to delink price from research, making health products cheaper and more easily available (HRC 2009a, 2010a; Forman 2013). However, while the Strategy and Plan of Action refer to WHO’s constitutional commitment to the right to health, the Task Force regretted that the drafters had deleted a reference to treaty provisions on the right to health and did not mention of the right to development principles in spite of the potential synergy between the Strategy and Plan of Action and the right to development (HRC 2009a, 2010a).

The Task Force additionally focused on MDG 8 and specifically Target 8.E, which calls on governments, “[i]n cooperation with pharmaceutical companies, [to] provide access to affordable essential drugs in developing countries” (UN General Assembly 2001). When the Task Force met with the WHO Secretariat in November 2008 to discuss global partnerships for access to essential medicines in developing countries, WHO agreed that the Strategy and Plan of Action could be used to explore with stakeholders the potential of the “Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines,” which had just been presented to the UN General Assembly by the Special Rapporteur on the right to health (UN General Assembly 2008), and the right to health as a basis to meet MDG Target 8.E on access to essential medicines (HRC 2010a).

The Task Force was specifically concerned that the Strategy and Plan of Action did not discourage the adoption of Trade-Related Aspects of Intellectual Property Rights (TRIPS)-plus protection in bilateral trade agreements, as discussed in chapter 17, or refer to the impact of bilateral or regional trade agreements on access to medicines. On the other hand, it looked favorably on the reference to attributes of accessibility, affordability, and quality of medicines in developing countries and on the position that protecting intellectual property should not impede states’ ability to comply with their core obligations under the rights to food, health, and education (Commission on Human Rights 2005a; HRC 2009b, 2010a). The Task Force also found the monitoring, evaluation, and reporting expectations of governments and industry to be consistent with right to development criteria, although it commented that improvements could be made to the WHO indicators.

6 The Strategy and Plan of Action calls upon states to take all necessary measures to ensure equality of opportunity for all in access to health services (WHA 2008), which was consistent, in the Task Force’s view, with the Declaration on the Right to Development, which resolves that: “States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to … health services …” (UN General Assembly 1986, art. 8.1).

2. Special Programme for Research and Training in Tropical Diseases

The second dimension of global health governance examined by the Task Force
was the Special Programme for Research and Training in Tropical Diseases (TDR). Co-sponsored by the World Bank, UNICEF, and WHO, the TDR seeks to advance research and implement practical solutions to neglected diseases, which it called “diseases of poverty.” The Task Force found that certain TDR projects were community-driven in ways that increased drug distribution, improved public services, and contributed to political empowerment and democratization, thus contributing to the realization of the right to development (HRC 2009a, para. 25; HRC 2010a, para. 46).7

The Task Force, however, noted that underfunding of these neglected diseases and the high price of medicines limited the TDR’s impact on innovation through research and development (HRC 2009b; HRC 2010a). The emergence of private foundations and non-governmental organizations was having considerable impact on efforts to combat infectious diseases, yet the Task Force expressed concern that the governance of these private sources of funding did not provide for adequate public accountability, in particular accountability for the failure of private entities to disclose the pricing of the products they develop. The Task Force underscored the need to strengthen transparency and accountability in the TDR’s contractual agreements with pharmaceutical companies on pricing and access to medicines, and to broaden the scope of independent reviews for mutual accountability (HRC 2010a; HRC 2009b).

The Task Force concluded that the TDR’s strategy was supportive of the right to development and the right to health insofar as it was rights-based, that it favored the empowerment of developing country efforts through partnerships and capacity-building, and that it focused on the needs of the most vulnerable (HRC 2010a). Referring to MDG 8, however, the Task Force noted the limited impact of the TDR on innovation with regard to infectious diseases. It supported further efforts by the TDR to introduce principles of the right to development in the design and implementation of relevant programs and to explicitly use a human right to health framework to focus on empowering developing countries and meeting needs of the most vulnerable (Ibid.).

7 The examined projects included community-driven interventions in Africa that increased the distribution of Ivomectin (a drug that treats river blindness) as a result of communities deciding how the drug will be used and distributed, controlling compliance with quality and quantity standards, and ensuring record keeping. The Task Force found that these community-driven initiatives “lead to better governmental services and contribute to an atmosphere of political empowerment and democratization basing research activities on people’s consent and involvement, all of which contribute to the realization of the right to development...” (HRC 2009a, para. 25).
3. The Global Fund to Fight AIDS, Tuberculosis and Malaria

The third mechanism of global health governance assessed by the Task Force was the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). As reviewed in chapter 19, the Global Fund has a shared objective to fight major diseases afflicting the world’s poorest people. The Task Force noted that, like the TDR, the Global Fund attempted to improve access to health and equitable development through procedures that were generally participatory and empowering (HRC 2009a, HRC 2010a).

Specifically, the Task Force found that the attention the Global Fund paid to equity, meaningful and active participation, and the special needs of vulnerable and marginalized groups was consistent with the right to development criteria (HRC 2009a, para. 20). However, the Global Fund did not apply a rights-based approach and, according to the Task Force, did not have adequate monitoring mechanisms for mutual accountability. Nevertheless, the Global Fund’s impact on national capacity to control the three diseases was especially relevant in the context of MDG 8. The task force felt that the Global Fund had “a vital role to play in developing a more enabling international environment for both health and development and contributing to the policy agenda for promoting public health, human rights and development” (HRC 2010a, para. 51).

In sum, the criteria developed by the Task Force on the implementation of the right to development were applied to several significant processes of global health governance in the context of its mandate to develop and apply right to development criteria to MDG 8. Beyond MDG 8, however, lie broader questions of how the normative and analytical framework of the right to development might be applied to the full range of global health governance institutions and functions.

B. Normative and Analytical Framework of the Right to Development and Global Health Governance

In the final phase of its work, the Task Force refined the methodology and structure of its evaluations, developing a full set of attributes, criteria, operational sub-criteria and indicators. The 2010 final product of the Task Force’s five-year effort was designed to operationalize the right to development and, as a consequence, is relevant to global health governance insofar as it provides clear and action-oriented guidance regarding the responsibilities of decision-makers in government, international institutions, and civil society for planning, implementing, monitoring, and assessing their development-related policies, projects, and processes (HRC 2010b). This framework begins with the core norm of the right to development, defined as “right of peoples and individuals to the constant improvement of their well-being and to a national and global enabling environment conducive to just, equitable, participatory and human-centred development respectful of all human rights” (Ibid., annex). Obviously, at this abstract level, WHO and other institutions of global health governance tend to articulate some version of “constant improvement of ... well-being” and often seek to encourage a “global enabling environment conducive to just, equitable, participatory development,” but are less likely to define development as “human-centred” and “respectful of all human rights.” The challenge, however, becomes more specific when it comes to the application of the criteria and sub-criteria to the three components or attributes of the right to
development, which the Task Force proposed and the OEWG had accepted: (1) comprehensive human-centered development, (2) enabling environment, and (3) social justice and equity. Under the first attribute (comprehensive and human-centered development policy), the first criterion is “[t]o promote constant improvement in socio-economic well-being,” and the first of five sub-criteria (that is, areas where progress can be measured) is health, with the other four relating to underlying determinants of health (education, housing and water, work and social security, and food security and nutrition). Indicators are suggested for each of these five sub-criteria, as indicated in table 1 below:

**Attribute 1: Comprehensive and human-centred development policy**

(A/HRC/15/WG.2/TF/2/Add.2, Annex.)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (a) To promote constant improvement in socio-economic well-being</td>
<td>1 (a) (i) Health</td>
<td>Public expenditures on primary health; life expectancy at birth; access to essential drugs; low birthweight babies; child mortality; HIV prevalence; births attended by skilled personnel</td>
</tr>
<tr>
<td>1 (a) (ii) Education</td>
<td></td>
<td>Public spending on primary education; school enrolment rates; school completion rates; international scores for student achievement</td>
</tr>
<tr>
<td>1 (a) (iii) Housing and water</td>
<td></td>
<td>Public expenditure on public service provision; access to improved drinking water and sanitation; homelessness rate; cost of housing relative to income; slum populations</td>
</tr>
<tr>
<td>1 (a) (iv) Work and social security</td>
<td></td>
<td>Long-term unemployment; involuntary part-time employment; public expenditure on social security; income poverty rates below national and international lines</td>
</tr>
<tr>
<td>1 (a) (v) Food security and nutrition</td>
<td></td>
<td>Child stunting rates</td>
</tr>
</tbody>
</table>

These indicators are to be used to assess the health component of the first criterion on improvement of socio-economic well-being of the attribute concerning development policy. Applied to health governance, the extent to which a health program would be deemed to make progress regarding the well-being criterion of the right to development would be measured by the advances made in the seven indicator areas covered by Sub-criterion 1 (a) (i) on Health. Similarly, the other four sub-criteria of the well-being criterion would be assessed as contributing to the right to development insofar as their respective
indicators show progress.

Other attributes and criteria are also relevant to assessing global health governance from the right to development perspective. For example, a sub-criterion in Attribute 1 on “health technology” appears under the criterion on “access to the benefits of science and technology,” with such indicators as “aid allocations to health technologies; use of TRIPS flexibilities, and price discounts to expand access to HIV antiretroviral drugs” (Ibid., annex). Attribute 2 on “participatory human rights processes” enumerates criteria and sub-criteria that could be used in reviewing the extent to which any global health governance program would be contributing to the right to development – as measured by explicit reference to human rights, prioritization of marginalized groups, measures to control corruption, genuine participation and voice of affected populations, monitoring and redressing violations of human rights, and ensuring transparency, accountability, and non-discrimination (Ibid.). Attribute 3 assesses the extent to which a health governance program contributes to social justice in development, as measured by such indicators as equality of opportunity in health, equality of access to resources and public goods, and reducing marginalization of least developed and vulnerable countries, as well as “safety nets to provide for the needs of vulnerable populations in times of natural, financial or other crisis” and “[e]limination of sexual exploitation and human trafficking, child labour, and slum housing conditions” (Ibid.).

Since the Task Force completed its work in 2010, the HRC and the UN General Assembly have adopted a series of resolutions calling for further study and refinement of the right to development criteria, and the OHCHR published a 2013 compendium of essays and analyses, Realizing the Right to Development: Essays in Commemoration of 25 Years of the United Nations Declaration on the Right to Development (OHCHR 2013). In a remarkably frank assessment, the then High Commissioner opened the compendium by stating:

Since the adoption of that landmark document [the 1986 UN Declaration], a debate has been raging in the halls of the United Nations and beyond. On one side, proponents of the right to development assert its relevance (or even primacy) and, on the other, sceptics (and rejectionists) relegate this right to secondary importance, or even deny its very existence. Unfortunately, while generating plenty of academic interest and stimulating political theatre, that debate has done little to free the right to development from the conceptual mud and political quicksand in which it has been mired all these years (Pillay 2013, iii).

After reviewing the history of the Declaration, its underlying principles, and the related challenges of international cooperation, this OHCHR study focuses on implementing the right through indicators, the MDGs, national experiences, the African Charter on Human and Peoples’ Rights, and the Task Force’s assessment criteria. A chapter on the lessons learned by the Task Force from efforts to operationalize the Declaration identifies seven features that have hampered progress: (1) the absence of explicit reference to human rights in the MDGs; (2) the deeper structural impediments to global economic justice, which the human rights mechanisms of the UN are unable to change; (3) the resistance from states and relevant institutions to addressing trade and lending from a right to development perspective; (4) the resistance by some states to the use of measurement tools; (5) the ambiguity of “global partnership;” (6) the lack of policy coherence and incentives to move from commitment to practice; and (7) the politicization of the necessary balancing of national and
international responsibilities to realize the right to development. The OHCHR study concluded by calling “for a transformative Post-2015 Development Agenda” (OHCHR 2013, 496). When the Post-2015 SDGs were passed, the Human Rights Council “[w]elcomed the adoption of the 2030 Agenda for Sustainable Development, and emphasized that the 2030 Agenda is informed by the Declaration on the Right to Development and that the right to development provides a vital enabling environment for the full realization of the Sustainable Development Goals” (HRC 2016b, preamble).

In an effort to apply the SDGs to the right to development, the Chair-Rapporteur of the OEWG submitted, at the request of OEWG, a set of “Standards for the implementation of the right to development” (HRC 2016a). While acknowledging that the report of the Task Force was “also relevant” to the preparation of standards, the OEWG proposed four new “standards for the implementation of the right to development,” which utilize a different methodology from the attributes-criteria-sub-criteria-indicators proposed by the Task Force. Standard 4 seems the most relevant to health governance insofar as it mentions international cooperation relating to health in the context of SDG 3 and calls for such cooperation “to overcome transnational epidemics such as tuberculosis, malaria, hepatitis, AIDS and other communicable diseases” and to achieve “universal health coverage and access to quality, essential health-care services, including access to safe, effective, quality and affordable essential medicines and vacancies” (Ibid., para. 37).

The UN General Assembly thereafter instructed the OEWG to “finalize consideration of the criteria and operational subcriteria, preferably no later than the nineteenth session of the Working Group [2018]” and appointed a Special Rapporteur on the right to development, with a mandate, inter alia, to “contribute to the promotion, protection and fulfilment of the right to development in the context of the coherent and integrated implementation of the 2030 Agenda for Sustainable Development” (HRC 2016b, paras. 13–14).

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8 Despite this absence, the 2000 Millennium Declaration, on which the MDGs are based, reaffirms state commitment “to making the right to development a reality for everyone and to freeing the entire human race from want” (UN General Assembly 2000, para. 11).

9 Standard 1 relates to “the necessary political will and commitment to realize the right to development”; standard 2 to the need for states to “cooperate to create the political, economic and social environment necessary to allow the implementation of the right to development”; standard 3 to focusing on the individual and promoting the right to development “at the national level, which requires a comprehensive and inclusive approach based on good, responsible governance”; and standard 4 on addressing “the most basic or core human needs…: poverty, the right to food, water and sanitation, health, education, housing and gender equality” (Ibid., para. 28-31).
Conclusion

Efforts to promote a rights-based approach to development have been more effective than those to promote the right to development. Introducing human rights into development planning, monitoring, implementation, and evaluation has made considerable strides since the 1993 Vienna Declaration and Programme of Action and the 2003 Common Understanding of the human rights-based approach to development cooperation. The right to development, however, has been less successful in meeting the objective, defined as early as 1979, to provide practical guidance for development activities. The emergence of the right to development in human rights diplomacy in the 1980s and subsequent efforts to translate this concept into meaningful development practice has been fraught with deep political divisions relating to aid effectiveness and national ownership, trade and investment, and lack of policy coherence and incentives to take practical steps. However, the claim that the norm is too vague to affect practice loses credibility in light of the work of the Independent Expert, the Task Force, the OHCHR Secretariat, and numerous scholars. The use of indicators and the drafting of a treaty on this right have been considered by some as obstacles to progress and by others as essential tools of its effectiveness.

Under these conditions, it is not surprising that economic institutions of significance to global health governance have not found it necessary or expedient to draw on the right to development to set priorities and guide practice and resource allocation for global health. Nevertheless, of the ten “global partnerships” the Task Force examined from the perspective of the right to development, the three relating to global health governance proved to be the most in agreement with the criteria, identifying how policy, processes, and outcomes can be improved by drawing on the right to development. Without incentives or instructions from their governing bodies, however, it is unlikely that this right will be prominent as a normative framework guiding institutions of health governance. Rather than relying on the political process of the OEWG and the UN General Assembly, those economic institutions with responsibilities for global health governance may find in the thirty years of efforts to promote this right a series of specific suggestions regarding the means and methods of translating the aspirations of the right to development into development practice, including in economic governance for global health.

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