HUMAN RIGHTS-BASED APPROACHES AND DOMESTIC LEGAL RESPONSES TO NCDS:
LESSONS LEARNED

TUESDAY, 22 SEPTEMBER 2015
THE HAGUE, NETHERLANDS

An expert meeting convened by the International Development Law Organization in collaboration with Global Health Law Groningen and the Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research.

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Humans rights-based approaches and domestic legal responses to NCDs: lesson learned. Expert Meeting. 22 September 2015, International Development Law Organization. The Hague, Netherlands.

BACKGROUND

DEVELOPMENT IMPACT OF NCDS

The World Health Organization has identified four major non-communicable diseases (NCDs) as challenges to human health and development in the 21st century: cardiovascular diseases (CVD), diabetes, cancer and chronic respiratory diseases. NCDs kill an estimated 38 million people each year. Globally, around sixteen million NCD deaths occur annually before the age of 70. Over 80% of these 'premature' deaths occur in low- and middle-income countries. Most of the world's population lives in countries where overweight and obesity kills more people than underweight. These premature deaths are largely preventable by tackling shared risk factors - tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

Health systems must also be strengthened to respond to the health care needs of people with NCDs. Premature deaths from NCDs reduce productivity, trap populations in poverty and curtail sustainable economic development. Morbidity and mortality also impact hugely on families and communities who must care for people with NCDs. The underlying determinants of these diseases and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required. Legislative and regulatory frameworks and legal practices are an essential part of the national response.

The inclusion of targets for NCDs in the Sustainable Development Goals (SDGs) presents welcome opportunities for the realisation of the right to health and the eradication of poverty. As with HIV and AIDS, human rights-based approaches offer an appropriate language and framework for identifying State responsibility and engagement of multiple actors (States, civil society, UN system, development agencies) in the global response. The relationship between NCDs and human rights-based approaches now needed to be more clearly articulated.

OBJECTIVES

The expert consultation aimed to:

1. Outline the current and anticipated future global burden of obesity and diabetes.
2. Review lessons learned from human rights-based approaches to HIV.
3. Identify how human rights-based approaches can be applied to NCDs.
4. Review how international trade and investment law can influence national responses to NCDs, with a particular focus on developing countries.
5. Review whether current international human rights frameworks are adequate to address NCDs, or do we need new sources of legal obligation?
6. Make recommendations for next steps for research, capacity building and networking to strengthen international and national legal frameworks to respond to NCDs.

EXPERT MEETING

The expert meeting was convened by the International Development Law Organization (IDLO) in collaboration with Global Health Law Groningen (GHLG) and the Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research (ESCR WG). It took place on Tuesday 22 September 2015 in IDLO Branch Office in The Hague, Netherlands.

The meeting brought together experts from academic institutions, government and civil society organizations with an interest in global health, law and human rights. The experts reviewed how international human rights law could contribute to the global response to non-communicable diseases (NCDs), and discussed whether new sources of legal obligation were needed. The issues were examined with reference to obesity, diabetes and unhealthy diets, however, the conclusions of the meeting contained lessons for all NCDs.

A background document prepared by the ESCR WG and published by IDLO and a draft Consensus Statement was circulated to participants in advance of the meeting for review and input.

The expert meeting was opened by Dr Ilaria Bottigliero, Director, Research and Learning (IDLO), Professor Brigit Toebes, GHLG and Mr Eduardo Arenas Catalán (ESCR WG). Their addresses were followed by plenary presentations from Dr David Cavan, International Diabetes Federation, 'Current and future global burden of diabetes, Mr David Patterson, IDLO 'Lessons from human rights-based approaches to HIV', Professor Brigit Toebes, GHLG 'Human rights-based approaches to NCDs' and Dr Benn McGrady, World Health Organisation 'International trade, law and global health'.

Following the plenary presentations, the expert meeting was organised into discussion groups on the following

topics: Development, Trade and Health; Civil Society and Community Engagement; Advertising, Media and Labelling; and, Academic Sector Capacity and Engagement. Each group discussed the same three questions:

1. How can the international human rights framework contribute to the global response to NCDs?
2. Are current international human rights frameworks adequate to address NCDs, or do we need new sources of legal obligation?
3. What are your recommendations for next steps for research, capacity building and networking to strengthen international and national legal frameworks to respond to NCDs?

Concluding remarks were made by Professor Brigit Toebes (GHLG), Ms Shamiso Zinzombe (ESCR WG) and Mr David Patterson (IDLO).

Outputs of the expert meeting include the meeting report, the background paper and the consensus statement.

KEY MESSAGES

1. The increase in recent decades in morbidity and mortality from non-communicable diseases such as diabetes and cardiovascular disease is largely preventable. Major factors risk factors include unhealthy diets and lack of physical exercise. These in turn are often due to structural and environmental factors such as urbanisation and lack of access to affordable, nutritious food in the urban environment.

2. The concept of 'human rights' provides the global language required to scale up action on non-communicable diseases. It also provides a legal and moral normative framework for delivering healthcare and addressing the underlying determinants of population health.

3. The solutions to all global health challenges require political engagement. In democratic societies, political engagement often comes from social mobilization. The concept of 'human rights' is a catalyst for social mobilization.

4. The value of a human rights-based approach to health is demonstrated by the global response to HIV. However NCDs present new challenges, and it is essential to critically assess the lessons from HIV and the experience of frameworks such as the Framework Convention on Tobacco Control (FCTC) to see how they might be effectively used or strengthened to better respond to NCDs.

5. The private sector has also begun to use 'human rights' language, often based on claims of freedom of expression and property rights. However, these claims should not be allowed to diminish State action on NCD prevention and control.

6. There is a dichotomy between international human rights law and international trade law. Human rights law empowers and even obliges states to take action to protect human health. Conversely, trade law may limit the ability of States to take action to protect health. Legal disputes between States seeking to legislate to protect public health and corporations representing the tobacco, food and beverage, and alcohol industries may arise at the domestic, regional and international levels.

7. The consensus statement annexed to this report reflects the broad agreement within the human rights and public health community on the need for comprehensive legislative and regulatory frameworks and legal practices to address NCDs and achieve the Sustainable Development Goal on health (SDG3) by 2030.

8. The participants at the consultation reaffirmed their commitment to contribute through research and other academic activities toward development and implementation of legal responses to NCDs within the sustainable development agenda.

PLENARY PRESENTATIONS

THE CURRENT AND FUTURE GLOBAL BURDEN OF DIABETES

Dr David Cavan delivered compelling data on the current global burden of diabetes and highlighted the urgency of a global intervention against NCDs. Globally eight percent of the adult population have diabetes, 90 percent of whom have Type 2 diabetes, which is largely preventable. Current projections were that by 2035 the number of people with diabetes will have increased by more than 50%.

Dr Cavan reviewed the epidemiology of Types 1 and 2 diabetes and the devastating effects on human health and wellbeing. Each year nearly five million people die from diabetes-related illnesses. Disability, stroke and blindness are all possible effects of either form of diabetes. The ripple effect of illness in adults of a working age includes loss of income. Treatment costs approximately $600 billion per year globally. Dr Cavan emphasized that these findings highlighted the urgency of implementing and monitoring the global action plan for the prevention and control of NCDs like diabetes.

The World Health Organisation in its NCD Global Monitoring Framework has set two goals that IDF is actively working towards: to halt the rise of diabetes and ensure 80% access to essential medicines by 2025.

Evidence has confirmed the causal link between physical inactivity and consumption of unhealthy foods, on the one hand, and on the other obesity and diabetes. Dr Cavan illustrated this link with the case of a two year old girl in the USA diagnosed with Type 2 diabetes, an illness commonly found in adults. Reversal of illness took place following improvements to her diet and level of physical activity.

The environment within which people live is a significant inhibitor or contributor to their health. Dr Cavan referred to 'food deserts', i.e. an environment with a scarcity of healthy foods. Such environments are more prevalent in populations with lower incomes. Dr David Cavan emphasised the need to address both the biological and structural factors leading to diabetes. These include improving access to healthy food and clean water; and improving opportunities for safe physical activity. These efforts needed to be multidisciplinary and multidimensional. Nutrition guidelines need to be reviewed, the public must be educated about the risk factors for diabetes and obesity, and access to healthy food and clean water must be assured.

LESSONS FROM HUMAN RIGHTS-BASED APPROACHES TO HIV

- ***'Human rights' provide the global language we need to scale up action on global health***

Human rights, as a global language, Mr David Patterson added, enables us to engage multiple partners outside the health sector. This was demonstrated by the response to the global HIV epidemic. Mr Patterson related how the first Director of the WHO Global Programme on AIDS, epidemiologist Dr Johnathan Mann, introduced human rights-based approaches to HIV in 1986. Other public health champions who have adopted the human rights-based approach include Indonesian paediatrician Dr Nafsiah Mboi, whose efforts lead to the General Comment 'HIV/AIDs and the rights of the Child', adopted by the Committee on the Rights of the Child in 2003. Key milestones included the creation of UNAIDS in 1996, with human rights and gender as cross-cutting themes, and the development of rights-based technical guidance, such as the International Guidelines on HIV/AIDS and Human Rights, and handbooks for legislators and judges.

- 'Global health challenges need political engagement. Political engagement comes from social mobilization. Human rights are the catalyst for social mobilization.'

Mr Patterson noted the political engagement generated by the human rights-based approach in countries like the United Kingdom, which in 2001 published a review of the domesitic implementation of the International Guidelines on HIV/AIDS and Human Rigts. He also noted the social mobilisation at the 2001 United Nations General Assembly Special Session on HIV/AIDS in the form of accredited NGOs, representing vulnerable and marginalised populations, including many HIV positive delegates. The resulting UN General Assembly Declaration of Commitment on HIV/AIDS includes multiple references to law and human rights. Another illustration was domestic and international mobilzation which forced 39 pharmaceutical companies to withdraw their legal challenge to reforms by Nelson Mandela's government to South Africa's ***Medicines Act.*** The amendments were intended to allow greater access to generic medicines for treating HIV and AIDS. Concluding, David Patterson noted the significant increases in resources for the global HIV response due, in part he suggested, to the framing of HIV prevention and treatment as a human rights issue. Human rights language, he pointed out, can similarly be harnessed to scale up global action on other global health challenges. Participants noted the need for global human rights language and that such language was being consolidated.

They noted the empowering nature of a human rights based approach to HIV, and the need for securing this level of engagement for NCDs.

HUMAN RIGHTS-BASED APPROACHES TO NCDS

Professor Brigit Toebes noted the added value of human rights-based approaches was central in developing legal responses to NCDs within the new Sustainable Development Agenda. Much information on food and health already existed in the public domain in countries similar to the Netherlands. Human rights offered legal redress and accountability, she emphasized, because of the legal stature of the treaties like the International Covenant on Economic, Social and Cultural Rights, and consequent states' obligations to respect, protect and fulfil relevant rights such as the right to health, and to life. This contributed both a moral and legal dimension to the discussion. The international human rights framework also provided guidance through General Comments, like General Comment 14 on the right to health, and the reports of the UN Rapporteur on the Right to Health. Professor Toebes noted that a helpful aspect of the right to health framework for the NCD debate is that the right to health clearly has these two dimensions: access to healthcare and securing the underlying determinants to health. It clearly points at the need to both secure access to healthcare services and to address the determinants to health (including lifestyle).

Professor Toebes noted that understanding the nature, content and limitations of human rights also contributed toward clarifying a human rights-based approach to NCDs. Underscoring this, she invited participants to reflect on the question, 'is a healthy lifestyle really a right given our own unhealthy habits like smoking?'

Using the question as a springboard, Professor Toebes argued that through a human rights-based approach we can deploy a framework which complements existing knowledge and action on the causes and impact of NCDs whilst protecting human health and dignity. Habit is influenced by environmental and structural factors: less privileged individuals are disproportionately affected. Human rights frameworks are connected with these environmental and structural factors through applicable human rights like the rights to development, food, health and work. Moreover, human rights provided language to protect less privileged individuals through the mandate on the state to ensure non-discrimination and protect the vulnerable and marginalised.

Further, human rights were interpreted in a manner that anticipated protection for new illnesses. Citing General Comment 14 paragraph 10 on the right to health, Professor Toebes drew attention to existing connections between the right to health and cancer, a formerly little known illness which was currently an epidemic. Furthermore, she highlighted CESCR General Comment 15, on the rights of the child, which explicitly referenced another new medical condition, childhood obesity.

Finally, she noted that human rights law expressly provided for the right to health care, and the importance of addressing the underlying determinants of health in the right to health. Professor Toebes stated these protections could be further concretised through benchmarks, illustrated by the tick box mechanism developed by the Danish Institute for Human Rights.

Participant interventions noted the differences between HIV and NCDs are an important analytical step toward framing a human rights-based approach to NCDs. Discrimination and national panic due to a fear of infection were all features of HIV. At the same time, panic created urgency and galvanised state action, and NCDs required a similar response. Professor Toebes agreed the human rights framework could be used to create a sense of urgency leading to prioritisation of NCDs.

Human rights frameworks were however limited. One pertinent limitation pointed out by Professor Brigit Toebes concerned access to expensive medicine. The state's obligation to progressively realise economic, social and cultural rights like the right to health, meant it may only be able to prioritise cheaper medication.

Another limitation concerned the human rights responsibilities of corporations. Professor Brigit Toebes noted weaknesses in the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises (John Ruggie's framework) on this matter, whilst recognising it provided an interesting point of departure. In 2011 Professor Olivier de Schutter, the then United Nations Special Rapporteur on the Right to Food, outlined concrete means in which the framework could be used in the context of the right to health and food. Concrete examples included a range of illustrations addressing the supply and demand of food, like imposition of taxation on soft drinks and other unhealthy foods and support for farmers markets and (peri) urban agriculture. Participants distinguished the significance of the consistency between de Schutter's recommendations and others like those of the International Diabetes Federation. The human rights community thus knew what needed to be done and its next step was implementation and testing effectiveness of the recommendations.

Beyond the food and beverage industry, participants drew attention to other corporate actors such as insurance

companies. They questioned whether they were also obliged to take part in preventative programmes. Also, property rights claimed by corporations concerned participants, who highlighted the FCTC as a legal example to learn from, in order to address this kind of challenge.

INTERNATIONAL TRADE, LAW AND GLOBAL HEALTH

Opening this discussion, Dr Benn McGrady observed,

> 'Some countries, including developed states like Australia, do not have a constitutional rights framework.'

Connecting this domestic legal challenge with international law, he observed a contrasting dichotomy in international law: while human rights law obliged and even empowered state action to protect, economic law restricted and even limited the ability of states to take certain actions. Elaborating, trade agreements typically oblige state parties to lower barriers premised on certain economic theories, which accepted the concept of 'winners and losers' as a given. Liberal markets were accepted to function as such. Dr McGrady noted the limited capacity of the state to regulate to protect public health in the face of the challenges of NCDs, and how limited capacity on international trade issues compounds the NCD capacity challenge. Enforceability also distinguished trade law from human rights law. Dr McGrady explained, trade agreements were highly enforceable, whereas human rights law lacked similar enforceability on the international level.

Trade agreements took many forms, Dr McGrady explained. The World Trade Organisation (WTO) Agreement is a multilateral system of prohibitions or negative integration, like its rules prohibiting discrimination. In contrast, he described the regional European Union model as a system of positive integration or harmonisation, requiring member states to adopt similar regulations subject to principles like proportionality. Bilateral and regional agreements like free trade agreements are experiencing resurgence. He emphasised they typically impose stronger protection in areas like intellectual property protection, even surpassing the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).

Dr McGrady pointed out these tensions in international law on health and trade manifested themselves in contemporary disputes. State efforts to enforce tobacco plain packaging, as in Australia's case, he explained, led to disputes in domestic, regional and international legal mechanisms. Contemporary disputes transcended the tobacco industry, he emphasised, noting that the food industry was also agitating against state initiatives to promote food labelling, like Ecuador's 2014 introduction of a traffic light system for salt, sugar and fat in foods. States face legal challenges even when they can demonstrate improvements in health outcomes since an intervention, leading to questions concerning the chilling impact of trade agreements on regulation.

In response to a question from participants on the role of the World Health Organisation as amicus curiae in the Uruguay case, Dr McGrady explained the WHO had contributed to the evidentiary base by supplying information. This is also consistent with legal principles, where an evidentiary test is a common feature in all laws. Regarding the impact of import duties on access to insulin in the EU, in response to a question from participants, Dr McGrady clarified that access depended on the trade agreement in question. Within the EU insulin moves freely without customs duty, however to enter the EU insulin may incur customs duties.

Contemporary disputes, he expressed, called to question the allocation of authority in international law.

> 'Who should have the authority to adjudicate complex questions concerning the impact of health regulation?'

Dr Benn McGrady noted arguments on regulation reveal competing conceptions of rights, with property rights, including in some cases the right to conduct business on the one hand, and on the other the state claiming right to regulate. Crucially, he stated,

> 'Human rights language is absent in this context. Yet there is a role of the language of rights to mobilise the public health community on these issues.'

In response to a participant's query as to whether WHO embraced human rights language, he confirmed whilst it was hard to generalise, the normative content held weight in WHO, as is reflected in the Constitution of WHO. Aptly, he concluded there was also a broader debate related to the conflict of laws that needs to be flagged for further action.

Participants reiterated these concerns, noting that the human rights community had entered this debate late in the day. They emphasised it was now time for action. Lawyers had to leave their comfort zones and engage in areas outside of their normal frameworks. Some participants pointed out corporations had already developed a 'human rights' language for the private sector. They called on colleagues to contest these claims by corporations. Further, they highlighted the need to engage

with other civil society actors, who have a very important role to play in the fight against NCDs.

HIGHLIGHTS FROM THE DISCUSSION GROUPS

The following are key points that arose during the discussions on specific topics:

DEVELOPMENT, TRADE AND HEALTH

How do our present frameworks contribute to dealing with NCDs?

- Trade law already contains some provisions on health; however, these are limited in reach as their focus remained trade-focused;
- Trade law and practice pay insufficient attention to human rights law and principles; 'Human rights' provides a language and framework that can be harnessed to engage actors from the trade sector;
- Some tools in trade law can be used to address NCDs. For example, the 2001 Doha Declaration on the TRIPS Agreement and Public Health need not be restricted to the issue of access to medicine;
- The Codex Alimentarius amongst other tools within the public health domain could also be harnessed in this area; and
- The Guiding Principles on Business and Human Rights could be useful; particularly the obligations on corporations to set up grievance mechanisms which might provide a remedy.

Do we need a new legal instrument?

- There is a need for further research on the peremptory norm status of human rights in relation to other areas of international law;
- As the Business and Human Rights framework is voluntary, it is essential to have an instrument capable of holding corporate actors to account, particularly given their use of property rights in the area of NCDs;
- The instrument should drafted to take into account current circumstances. For example, a WTO Declaration similar to the 2001 Doha Declaration would be possible if similar circumstances existed. In 2001, these included unreasonable conduct on the part of pharmaceutical companies, and a push from civil society;
- A General Comment on NCDs is a feasible option because of the length of time that has elapsed since General Comment 14, the evolution of law in that period, and the new knowledge on the realities of globalization. An update was due given these developments;
- Recognition is required for civil society's contribution to the human rights framework, such as the notion of food sovereignty developed by La Via Campesina, which could be harnessed in support of a legal response to NCDs; and
- It is not yet clear what role the World Health Organisation's draft Framework of Engagement with Non State Actors (FENSA) could play in these issues.

CIVIL SOCIETY AND MEDIA ENGAGEMENT

How can the international human rights framework and organizations contribute to the global response to NCDs?

- Use existing tools within WTO framework, investment tribunals and other dispute settlement mechanisms;
- Advocate for a new treaty, the implementation of existing treaties, thwarting regression in human rights standards, campaign against joining inequitable trade agreements, and minimise harmful provisions in proposed trade agreements;
- Use public interest litigation;
- Build civil society capacity especially at UN level; particularly of smaller organisations that lack the same level of traction bigger organisations have;
- Develop civil society capacity and strategies to inform communities about NCDs and the need for legal regulation, such as by educating and empowering communities to engage meaningfully in national dialogues.
- At the regional and global level, civil society should be supported to participate meaningfully in UN processes on NCDs prevention and control – for example by submitting shadow reports under the Universal Periodical Review mechanism;
- Civil society has the potential to unite perspectives on trade and health by providing comprehensive information, to make sure key issues do not fall through gaps;
- Civil society should explore the possibility of more North-South and South-South collaboration; and
- Civil society can cleverly deploy existing tools within its human rights tool box, like naming and shaming.

Are current international human rights frameworks adequate to address NCDs, or do we need new sources of legal obligations?

- There is a need for more legal tools to hold relevant actors accountable, including defining responsibilities for everybody;
- The WTO needs improved conflict of interest rules and appeals mechanisms. In addition, substantive rules protecting health should also be developed;

- The current fragmented and ad hoc nature of NGO lobbying of UN agencies and members is not productive. Once a year (September) is insufficient - continuous engagement is necessary, civil society should play a bigger role at this level. A mechanism to make sure this takes place should be strengthened (including building on the WHO Global Coordination Mechanism);
- Based on previous experience, including the FCTC, the impetus for a new convention has to come from civil society in order to galvanise action at UN level. It is also important to mention any legal document will necessarily have to balance political feasibility and legal strength; and
- UN treaty bodies should be encouraged to follow-up on state party non-compliance with reporting requirements in the context of NCDs.

Recommendations for next steps for research, capacity building and networking to strengthen international and national legal frameworks to respond to NCDs

- There is a need for more evidence around whether a more general human rights framework or more targeted campaigns are more effective;
- An in-depth examination is required of the outcomes of the SDGs including the funding mechanisms and authority;
- To improve accountability, civil society should encourage states to abide by their reporting obligations – civil society capacity building may be needed to do so; and
- Countries should be encouraged to prioritize research, capacity building and networking on specific NCDs according to their national contexts.

ADVERTISING, MEDIA AND LABELLING

Balancing competing rights:

- We need to better understand how to strike a balance between trade law and human rights law;
- More clarity is needed on whether corporations can be rights holders, or are only duty bearers. This question arises when considering the right to property versus human rights obligations. Academia is encouraged to re-engage in the discussion of whether corporations can be right holders;
- There are challenges in balancing the right to freedom of expression (as claimed by advertising companies) with human rights. A framework is needed - there is a need for proportionality;
- There is significant opposition by economic interests (industry sector); the right to free expression is now used for advertising and commercial information; and
- Courts need to be assisted to bring more rigor to an examination of these issues.

Capacity building:

- Due to vulnerability and lack of capacity, many developing countries risk compromising the rights of their citizens in an attempt to bring business into their country;
- There is a need for capacity building of state actors, including current and future government legal advisors. This can begin at the university level;
- Capacity building on NCDs and law should include the international guidance now available; and
- Industry has proven to be creative in responding to legal challenges by countries, and it has aggressive and capable lawyers to convincingly present its case in dispute resolution forums.

Areas for further research:

- Better understanding is needed of the differences between the tobacco, beverage, alcohol and food industries (e.g. their various capacities to lobby governments);
- The NCD - human rights framework is not yet well developed. There is a need to further develop the evidence base, i.e. an understanding of the determinants to health, the underlying causes of NCDs, and to promote continuous monitoring and evaluation;
- There is a need to expand and clarify the human rights-based approach, particularly in relation to the right to health and the right to food. Furthermore, it is necessary to understand how the human rights approach can support other approaches, rather than compete with them; and
- A good starting point is to mobilize around the rights of the child. This has been a useful tool to build the evidence base and gain public attention and support.

Issues at local level:

- There is a challenge in galvanizing political will to support regulations on advertising to address NCDs;
- Human rights-based interventions also need to be cost effective; and
- Local lawyers and local CSOs need to be engaged to address the social determinants of health.
- Academic Sector Capacity and EngagementThere is a need for a multidisciplinary framework to address the right to health and NCDs;
- Curriculums relating to other disciplines, including the medical profession, health economics, agriculture, social science, political science and

public health all need to be revised to incorporate human rights-based concepts and approaches;

- Learnings from public health experts and other legal scholars specializing in, for example, tobacco control or HIV, need to be adopted by health and human rights scholars. Similarly, human rights scholars could advise the medical community as well as policy makers, for example with respect to the legal implications of preventative measures and the impact of certain measures on human rights; and
- There is a need for improvement in public relations by the human rights community, especially in its ability to reach out to prominent health institutions such as the WHO.

RECOMMENDATIONS FOR FURTHER RESEARCH, CAPACITY BUILDING AND NETWORKING

The participants then discussed recommendations for further research, capacity building and networking. They noted that:

- comprehensive legislative and regulatory frameworks and legal practices are an essential part of the national response to NCDs; that
- States' actions on NCDs must be consistent with their international legal obligations; and that
- WHO standards and guidance on evidence-based actions to address NCDs will assist determine these obligations.

There was agreement that more discussions are needed on ways to strengthen the current legal framework for tackling NCDs. This includes the possibility of adopting a specialized international legal instrument, within the framework of the World Health Organization. Such an instrument should be based on existing experiences with the FCTC, other international instruments including the Codex Alimentarius, and domestic legislation. These recommendations are expanded below.

Research

Further research was required on a number of key issues including on:

1. the peremptory norm status of human rights;
2. the most effective legal instrument for a human rights based response to NCDs;
3. strategies to address claims for corporate human rights protection;
4. industrial differences, such as those between the tobacco and food industries, so as to understand and better leverage industrial differences;
5. the notion and full implications of underlying determinants of health, like the connection between food and health, in order to gain a deeper understanding;
6. enhancing complementary synergies between human rights and other approaches; and
7. curriculum development from a multidisciplinary perspective covering all three levels of education.

Capacity Building

Activities for capacity building on human rights and NCDs should encompass:

1. A clear response to epidemiological data which demonstrated an urgent need for a global response and action on non-communicable diseases to halt the increasing prevalence of mostly preventable illnesses and treat individuals already affected by illness;
2. Lessons from the Global Diabetes Plan 2011 – 2021 which provides a template useful in prevention and control of other NCDs, key lessons of which included noting that effectively responding to NCDs requires addressing contributing environmental and structural factors;
3. Scaling up global action by incorporating legal action from human rights-based frameworks following consolidation of a global language on human rights, based on an understanding of the nature, content and limitations of human rights and in this way harness the possibilities of accountability and legal redress in a manner complementary to existing knowledge on food and health;
4. Strategy development to reclaim human rights language from industry given especially corporations increasingly claim human rights protection in the form of property rights or freedom of expression when confronted about their NCD creating/ making/ promoting conduct;
5. Utilisation of existing tools within trade law, like the Doha Declaration on Public Health, and public health like the FCTC and human rights like the principles on human rights and business;
6. Work toward a new legal instrument clearly defining the legal responsibilities of all relevant actors, proposals for a new instrument include a treaty, general comment and guidelines, research should be used to guide in the selection of the instrument;
7. Utilisation of research on the peremptory norm status of human rights;
8. Work should also address the underlying international law issue of conflict of laws because of competing conceptions of rights of business in trade law on the one, and human rights of people on the other;and
9. Active support to develop the capacity building needs of developing countries and NGO's to effectively respond to NCDs as a matter of priority.

Networking

Proposals for networking include:

1. Greater space within UN processes for civil society, particularly smaller organisations from the South, to participate more meaningfully in its proceedings and also recognise the substantive value of their contributions. Practical ways of accomplishing this include the creation of a specialised UN mechanism to ensure continuous engagement with civil society;

2. Simultaneously and independently civil society should organise itself as a forum for more effective structured and unified and coordinated engagement with UN agencies; and
3. A framework and schedule for future joint action planning and action on NCDs and the law should be developed.

CONSENSUS STATEMENT

Participants then considered and adopted the Consensus Statement (see Annex) and discussed its dissemination. Persons who did not endorse the Consensus Statement for institutional or other reasons are recorded as 'Observers' to the Consultation.

ANNEXES

ABOUT IDLO

IDLO enables governments and empowers people to reform laws and strengthen institutions to promote peace, justice, sustainable development and economic opportunity.

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HUMAN RIGHTS-BASED APPROACHES AND DOMESTIC LEGAL RESPONSES TO NCDS: LESSONS LEARNED

EXPERT MEETING

Tuesday, 22 September, 2015
9:30 – 17:00

Reception 17:00 – 18:00

Hosted by the International Development Law Organization (IDLO)
In collaboration with:
Global Health Law Groningen
&
Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

CONSENSUS STATEMENT

PREAMBLE

On 22 September 2015, the International Development Law Organization (IDLO), in collaboration with Global Health Law Groningen and the Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research, convened a meeting of experts in international law and global health law. The experts reviewed how international human rights law can contribute to the global response to non-communicable diseases (NCDs), and discussed whether new sources of legal obligation were needed. The issues were examined with reference to obesity, diabetes and unhealthy diets, however the conclusions of the meeting contain lessons for all NCDs.

NCDS THREATEN SUSTAINABLE DEVELOPMENT

We welcome and affirm the proposed United Nations framework on a sustainable development agenda, specifically as it relates to NCDs.

We recall the World Health Organization has noted that:

- NCDs are the greatest cause of preventable illness, disability and mortality worldwide, leading to 38 million deaths annually, almost three-quarters of which occur in low- and middle income countries;
- Sixteen million NCD deaths occur before the age of 70; 82% of these "premature" deaths occurred in low- and middle-income countries;
- These premature deaths are largely preventable by tackling shared risk factors – tobacco use, unhealthy diets, physical inactivity and the harmful use of alcohol;

- Children and youth are also affected by treatable NCDs, and many of the behaviors that lead to adult NCDs start during childhood and adolescence;
- In low-resource settings, health-care costs for cardiovascular diseases, cancers, diabetes and chronic lung diseases can quickly drain household resources, driving families into poverty;
- The exorbitant costs associated with NCDs, including often lengthy and expensive treatment and loss of breadwinners, are forcing millions of people into poverty annually, stifling development.

INTERNATIONAL AND NATIONAL LEGAL FRAMEWORKS

We recognize that:

- All human rights are implicated in the response to NCDs, including among others the rights to health, food and development;
- The right to health stresses two dimensions: access to healthcare, including access to medicines, and access to the underlying determinants of health; thus stressing the need to progressively realize people's access to healthcare services, as well as the conditions in which people can lead a healthy life;
- Access to healthcare encompasses access to affordable diagnosis and treatment, including palliative care, and safe and effective medicines of assured quality and in sufficient quantity to treat NCDs; the underlying determinants of health include access to affordable, safe and healthy food and nutrition, access to safe and potable water and adequate sanitation, safe and healthy working conditions, housing, and a healthy environment;
- Children and youth with NCDs require access to health care, education, and community services that are specific to their and their families' needs;
- International, regional and national responses to HIV based on human rights, as well as the Framework Convention on Tobacco Control (FCTC) – with special attention to the conditions of trade and investment treaties, provide valuable lessons for the response to NCDs.

We further recognize that:

- NCDs take a higher toll on developing countries due to social and economic inequalities, impacting negatively on the right to development; North-South and South-South cooperation in the prevention and control of NCDs is important for the prevention and control of NCDs;
- Responding to NCDs demands multisectoral, whole-of-government and whole-of-society responses;
- Excessive focus on personal responsibility distracts the attention from urgently needed action on the social determinants of health in order to prevent and control NCDs;
- Opportunities to prevent and control NCDs occur at multiple stages of life; interventions in early life often offer the best chance for primary prevention;
- Comprehensive legislative and regulatory frameworks and legal practices are an essential part of the national response; States' actions on NCDs must be consistent with their international legal obligations; WHO standards and guidance on evidence-based actions to address NCDs will assist determine these obligations.

- More discussions are needed on the possibility of adopting a specialized international legal instrument, within the framework of the World Health Organization, which could strengthen the current legal framework for tackling NCDs, based on existing experiences with the FCTC, other international instruments including the Codex Alimentarius, and domestic legislation.

This Consensus Statement was adopted by the participants in their individual capacities at the Expert Meeting on Human Rights-based Approaches and Domestic Legal Responses to NCDs: Lessons Learned, which took place in The Hague, The Netherlands, on 22 September 2015.

HUMAN RIGHTS-BASED APPROACHES AND DOMESTIC LEGAL RESPONSES TO NCDS: LESSONS LEARNED

EXPERT MEETING

Tuesday, 22 September, 2015
9:30 – 17:00

Reception 17:00 – 18:00

Hosted by the International Development Law Organization (IDLO)
In collaboration with:
Global Health Law Groningen
&
Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

Focus Questions

1. How can the international human rights framework contribute to the global response to NCDs?
2. Are the current international human rights frameworks adequate to address NCDs, or do we need new sources of legal obligation?

PROGRAM

09:30 - 10:00 Registration

10:00 – 10.30 Welcome and introductions:

- Dr Ilaria Bottigliero, Director, Research and Learning, IDLO
- Professor Brigit Toebes, Global Health Law Groningen
- Eduardo Arenas Catalán, Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

10:30 – 11.00 Plenary presentation:

1. Current and future global burden of NCDs, Dr David Cavan, International Diabetes Federation

11:00 – 11.30 Refreshment break

11:30 – 13.00 Plenary presentations:

2. Lessons from human rights-based approaches to HIV, Mr David Patterson, IDLO
3. Human rights-based approaches to NCDs, Prof. Brigit Toebes, Global Health Law Groningen
4. International trade, law and global health, Dr Benn McGrady, World Health Organization

13:00 – 14.00 Lunch

14.00 – 15.15 Discussion Groups

1. Development, trade and health
   Chairperson: Shamiso Zinzombe, Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

2. Civil society and community engagement
   Chairperson: Amy Eussen, NCD Child

3. Advertising, media and labelling
   Chairperson: Lottie Lane, Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

4. Academic sector capacity and engagement
   Chairperson: Professor Brigit Toebes, Global Health Law Groningen

15.15 – 15.30 Refreshment break

15.30 – 16.00 Discussion group reports

16.00 – 17.00 Plenary discussion and recommendations

Chairperson: Dr Lankhorst, Head of Research, IDLO

Adoption of Consensus Statement

- Lottie Lane and Yi Zhang, Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research

Concluding remarks

- Professor Brigit Toebes, Global Health Law Groningen
- Shamiso Zinzombe, Institute of Health Policy and Management, Erasmus University
- David Patterson, Senior Legal Expert, Health, IDLO

17.00 – 18.00 Refreshments and Networking

HUMAN RIGHTS-BASED APPROACHES AND DOMESTIC LEGAL RESPONSES TO NCDS
EXPERT MEETING IN THE HAGUE
Tuesday, 22 September, 2015

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HUMAN RIGHTS-BASED APPROACHES AND DOMESTIC LEGAL RESPONSES TO NCDS: LESSONS LEARNED

EXPERT MEETING

22 September, 2015

BACKGROUND DOCUMENT

CONTENTS

EXECUTIVE SUMMARY

On 22 September 2015 international lawyers and public health experts will convene in The Hague, Netherlands, to discuss critical issues relating to non-communicable diseases and law. The expert meeting will address first, how can the international human rights framework contribute to the global response to NCDs? Second, are the current international human rights frameworks adequate to address NCDs, or do we need new sources of legal obligation? Issues will be discussed in depth with reference to obesity, diabetes and healthy diets, however, the conclusions will contain lessons for other non-communicable diseases. This background paper is intended to inform these discussions.

From 25 to 27 September 2015 at its 70th Session, the United Nations General Assembly is set to consider and adopt the Sustainable Development Goals. These goals build on lessons learnt from the formulation, implementation and evaluation of the Millennium Development Goals. Welcome inclusions within these goals are Goals 3 which references non-communicable diseases and Goal 16 on access to justice and good governance. This reaffirms United Nations General Assembly's Political Declaration of 2011, which identified four major NCDs as challenges to human health and development in the 21st century: cardiovascular diseases, cancer, chronic respiratory diseases and diabetes.

Obesity is a complex condition, which increases the likelihood of cardiovascular disease, diabetes and some types of cancer. In 2013, 42 million children below the age of 5 were obese or overweight, and in 2014 over 600 million adults were obese. In 2010 it was estimated approximately 3.4 million people die from overweight and obesity per year. The epidemiology of obesity is multifaceted. It involves structural factors, like the international political economy, trade and the activities of the food and beverage industry, in particular transnational companies. In addition, it involves biological factors and social factors, such as physical inactivity and income status. Like obesity, other NCDs are affected by a number of underlying social, economic, cultural and political determinants of health and structural barriers.

The explicit adoption of the human rights-based approach shifted the focus from HIV as an illness affecting minorities and poor people in economically developed countries and the Global South, to a global public challenge with State responsibility identified and State action monitored and scrutinized. With this shift came massive financial resources, including to strengthen legal frameworks and protection for people with HIV and other key affected populations. There are many lessons from the rights-based approach to HIV for other global health challenges. Similarly, the Framework Convention on Tobacco Control 2003 builds on the human rights based approach to epidemics. Within a global public health and human rights framework, it clearly addressed causes of the epidemic, like complicated factors such as trade liberalization, direct foreign investment and tobacco advertising, promotion and sponsorship.

National and international capacity for similar application of human rights-based approaches in the context of obesity exists, as to do lessons for other non-communicable diseases. Key elements of the right to health in Article 12 of the International Covenant on Economic, Social and Cultural Rights 1966 and the rights of the child, including in the Convention on the Rights of the Child 1989 are instructive. In particular, Article 12 provides a holistic framework that addresses prevention, control and treatment, and underlying determinants of health, like food, water and education. Also, the rights of the child cover similar territory, including prenatal and postnatal care for the mother.

Finally, proposals for a treaty on obesity the Draft Convention to Promote and Protect Healthy Diets are useful.

In conclusion, the inclusion of non-communicable diseases in the Sustainable Development Goals is welcome. It reaffirms states prior political commitments including in the context of advancing human rights. Further, human rights clearly provide a holistic means of addressing global public health challenges posed by epidemics. This has been demonstrated in the context of HIV/AIDS and tobacco. Existing human rights like the right to health and the rights of the child provide a basis on which to construct such a framework. There may also be an opportunity to strengthen these by further clarifying obligations in a new international legal instrument.

PART I INTRODUCTION

On 22 September 2015 international lawyers and public health experts will convene in The Hague, Netherlands, to discuss critical issues relating to non-communicable diseases and law.[1] The expert meeting will address two questions:

a) How can the international human rights framework contribute to the global response to NCDs?

b) Are the current international human rights frameworks adequate to address NCDs, or do we need new sources of legal obligation?

The issues will be examined in depth with reference to obesity, diabetes and healthy diets; however, the conclusions will contain lessons for other NCDs. This background document is intended to inform these discussions by summarizing the relevant existing law, practice and guidance.[2] The expert meeting will also consider for adoption a consensus statement on NCDs and law.

In February 2016, the United Nations Inter-Agency Task Force on NCD Prevention and Control (UN Task Force) will hold a thematic discussion on NCDs and law.[3] The consensus statement of The Hague expert meeting in September 2015 will be included in the background materials for the UN Task Force meeting, and contribute to the design of the UN Task Force work plan on NCDs and law.[4]

1. Health and Development: from Millennium to Sustainable Development Goals

The United Nations General Assembly is set to consider and adopt the proposed Sustainable Development Goals (SDGs) at its 70th Session to be held from 25 to 27 September 2015. The SDGs build on lessons learnt from the formulation, implementation and evaluation of the Millennium Development Goals (MDGs).[5] The main emphasis of the draft SDGs reaffirms eradication of poverty and hunger. The SDGs are universal in application and not exclusively intended for developing states. In addition, they recognise individual countries face different challenges, thus, rather than prescribe one model of development there are possibilities to explore differing developmental models complying with the framework.[6] Furthermore, similar to MDGs, the draft SDGs affirm that international human rights principles are critical founding principles and implementing tools.[7]

[1] 'Human rights-based approaches and domestic legal responses to NCDs: lessons learned' Expert meeting hosted by the International Development Law Organization (IDLO) in collaboration with Global Health Law Groningen and the Economic, Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research, the Hague, 22 September 2015.

[2] This background paper was prepared by Dr Shamiso Philomina Zinzombe, lead author, and Eduardo Arenas Catalán, Lottie Lane, and Yi Zhang of the Social and Cultural Rights Working Group of the Netherlands School of Human Rights Research. Contributions were also received from Professor Dr Brigit Toebes of the Faculty of Law at the University of Groningen. The views expressed in this paper are not attributable to individual authors nor do they necessarily reflect the policies of the International Development Law Organization or the University of Groningen.

[3] New York, 10-12 February 2016. The meeting will be organized by IDLO, in collaboration with WHO, UNDP and other interested Task Force Members.

[4] See generally http://www.who.int/nmh/ncd-task-force/en/ (accessed 27 July 2015)

[5] UNGA 'Draft outcome document of the United Nations summit for the adoption of the post-2015 development agenda' (12 August 2015) UN Doc A/69/L.85 (UN Doc A/69/L.85).

[6] UN Doc A/69/L.85 page 2-7.

[7] For example, 'The new Agenda recognizes the need to build peaceful, just and inclusive societies that provide equal access to justice and that are based on respect for human rights (including the right to development), on

A welcome inclusion is Sustainable Development Goal (SDG) 3, which includes a reference to non-communicable diseases (NCDs), and SDG 16 on access to justice and good governance.[8] This is consistent with the UN General Assembly's Political Declaration of 2011, which identified four major NCDs as challenges to human health and development in the 21st century: cardiovascular diseases (CVD), cancer, chronic respiratory diseases and diabetes.[9] It is estimated NCDs prematurely killed 38 million people in 2012. Around 16 million of these NCD deaths occurred before the age of 70. Some four in five of these deaths occurred in developing states.[10] These deaths are largely preventable by tackling four shared risk factors - tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.[11] Health systems must also be strengthened to respond to the health care needs of people with NCDs. Premature deaths from NCDs trap populations in poverty and hugely impact families and communities who must care for people with NCDs. Further, sustainable economic development is curtailed through a reduction of productivity.

Obesity is a complex condition, which increases the likelihood of CVD, diabetes and some types of cancer.[12] In 2013, 42 million children below the age of 5 were obese or overweight, and in 2014 over 600 million adults were obese.[13] In 2010 it was estimated approximately 3.4 million people die from overweight and obesity per year.[14] The epidemiology of obesity is multifaceted as it involves structural factors, such as the international political economy, trade and the activities of the food and beverage industry, in particular transnational companies. In addition, it involves biological factors and social factors, such as physical inactivity and income status, with vulnerability depending on whether or not one resides in a developed or developing state.[15] Like obesity, other NCDs are affected by a number of underlying social, economic, cultural and political determinants of health and structural barriers.

The underlying determinants of these diseases and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required. Legislative and regulatory frameworks and legal practices are an essential part of the national response. The human rights-based approach provides a holistic legal architecture with which to address the prevention, treatment and control of NCDs, including their underlying determinants.[16] As with HIV and AIDS, human rights-based approaches offer an appropriate language and framework for identifying State responsibility and engagement of multiple actors (States, civil society, UN system, development

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effective rule of law and good governance at all levels and on transparent, effective and accountable institutions.' UN Doc A/69/L.85 para. 35.

[8] UN Doc A/69/L.85 Goal 3, Goal 16.

[9] 'Political Declaration of the High-Level meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases' A/66/L1; UNDP 'Discussion Paper Addressing the Social Determinants of Noncommunicable Diseases' (*UNDP*, 2013) (UNDP 2013 Discussion Paper) page 7.

[10] WHO, 'Global Status Report on noncommunicable diseases 2014' (*WHO*, 2014) (WHO 2014 NCD Status Report) page xi ,UNHRC ' Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover Unhealthy foods, non-communicable diseases and the right to health' (1 April 2014) UN Doc A/HRC/26/31 (UN Doc A/HRC/26/31) para 2;UNDP 2013 Discussion Paper page 11 in 2010 NCDs accounted for nearly 35 million of the 53 million global deaths, killing more people than all other causes combined.

[11] Tara Voon *Regulating Tobacco, Alcohol and Unhealthy Foods* (Routledge 2015).

[12] WHO 2014 NCD Status Report page xiv, 79, UN Doc A/HRC/26/31 para 2.

[13] Media Centre, 'Factsheet No 311 Obesity and Overweight' (*WHO*, 2015).

[14] WHO 2014 NCD Status Report page 79.

[15] Text para 2-3.

[16] See generally hrbaportal.org (accessed 4 August 2015).

agencies) in the global response to NCDs. The specific application of international human rights law to NCDs now needs to be more clearly articulated.[17]

PART II EPIDEMIOLOGY OF OBESITY AND DIABETES

The epidemiology of obesity is multi-layered. Its causes include a series of biological and structural factors. Its impact is devastating on human health and development. Prevention and treatment options responsive to its causes exist. Each dimension of the epidemiology of obesity shall be discussed in this section.

2. Obesity, Diabetes, Healthy Diets and Physical Activity

2.1 Biological and Structural Causes and Risk Factors of Obesity and Diabetes

Obesity is defined as abnormal or excessive fat accumulation that may impair health.[18] Overweight and obese pregnant women are at an increased risk of gestational diabetes, which is a risk to both mother and child during pregnancy and at birth. Further, the child becomes at risk of acquiring diabetes and CVD later in life. In turn diabetes affects the body's ability to fight infection, thus, increasing risks to other illnesses such as tuberculosis.[19] Foetal malnourishment is also a risk to a child becoming obese later in life.[20] Childhood obesity increases the child's risk of mental illness and gastrointestinal complications. It also increases child comorbidities from CVD and diabetes. Finally, longitudinal studies suggest, even when a person who was previously an obese child attains a normal body mass index (BMI) in adulthood, some of the risks associated with childhood obesity remain, such as premature death.[21]

Other risk factors of obesity include unhealthy diets and physical inactivity. Unhealthy diets include consumption of high levels of processed and refined foods, sugar, salt and sugary drinks, and consumption of unhealthy fats such as trans-fats and saturated fats. These are commonly found in cheap ready-made meals, such as those sold at fast food outlets and supermarkets, amongst other food stuffs. Both risk factors are an outcome of biological and structural factors.

The global obesity epidemic began in developed states in the 1970s and 1980s but it is now also increasingly prevalent in developing states. According to studies, one of the structural causes of this shift is the 'nutrition transition', wherein early in the economic development process high income groups consume unhealthy diets, with low physical activity. Further into the development process unhealthy diets and physical inactivity become increasingly prevalent among lower income groups and less so among higher income groups. Obesity presently largely affects higher income or educated groups in developing states, whilst the opposite is true in developed states where obesity affects those with lower incomes or education. It is also reported that, in both developed and

[17] WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 (*WHO*, 2013) (WHO 2013 Global Action Plan) page 12, FAO and WHO, 'Rome Declaration on Nutrition' November 2014, Doc ICN2 2014/2.
[18] WHO 2014 NCD Status Report page 79; UNDP 2013 Discussion Paper page 15 the body mass index (BMI), a unit of measuring body fat based on a person's height and weight, is one of the tools commonly used to measure obesity. A person with a measure equal to or greater than 30 is in general classified as obese although some exceptions exist.
[19] UNDP 2013 Discussion Paper page 16.
[20] UNDP 2013 Discussion Paper page 16; World Health Organisation, 'Interim Report of the Commission on Ending Childhood Obesity' (*WHO*, 2015) (Interim Report Commission Child Obesity) page 7, 9.
[21] Interim Report Commission Child Obesity page 6.

developing states, the prevalence of obesity among low income women is increasing at a rate higher than the comparable rate among high income women.[22] Another of the structural causes is the 'physical activity transition'. In children it involves reduced opportunities for physical activity in and out of school, and an increase in time spent on sedentary leisure activities, features consistent with globalisation and urbanisation in developed and developing countries.[23] In adult women physical inactivity can result from gender norms and concerns such as safety fears in certain areas.[24] Body image and perceptions of healthy body derived from cultural norms and practices also contribute to the onset of obesity in children.[25] Given the nutrition and physical activity transitions, the WHO Global Commission on Ending Childhood Obesity has noted that 'it is instructive that none of these causal factors are in the control of the child and childhood obesity cannot be seen as the result of lifestyle choices by the child – this distinction contrasts with common perceptions of adult obesity (even though this perception is also faulty)'.[26]

2.2 Social and Developmental Impact

The social and developmental impact of obesity and diabetes include premature death and inability to attend school and retain employment due to ill health. In low income settings this can also compound the experience of poverty.[27] Whilst information on NCD health expenditure in developing countries is rare, some countries can already show the impact on their health systems. In 2006 Mexico spent 6.7 percent of its health budget treating diabetes, obesity and cardiovascular disease. It is expected that costs in low income countries will increase and in some cases at rates higher than those in high income countries.[28] There is a disproportionate impact on women and girls, who may be both directly affected and have to care for family members who are ill or disabled. Finally, due to premature death and an inability to regularly attend to work because of ill health, obesity can have a devastating effect on a developing economy.[29]

2.3 Prevention and Treatment

Primary prevention of obesity includes a healthy diet and adequate physical exercise. Adults need 150 minutes of moderate exercise per week, children require 60 minutes a day. Healthy diets include fruit and vegetables, and adequate potable water. States should ensure a food system that provides an adequate supply of safe, affordable and nutritious food for all; thus, adhering to the principles of food and nutrition security[30] and food sovereignty.[31] In relation to exercise this requires public policy programming in private and public spaces promoting exercise for adults and children. Treatment for obesity related diseases such as diabetes, cancer and respiratory ailments requires a health system capable of providing, among other things, access to medicine and other treatments. For children, treatment and prevention requires policy interventions based on the life course, these commence prior to conception covering the duration of a child's life up to adulthood and conception of the next

[22] UNDP 2013 Discussion Paper page 26-29.
[23] Interim Report Commission Child Obesity page 9.
[24] UNDP 2013 Discussion Paper page 29.
[25] Interim Report Commission Child Obesity page 7
[26] Interim Report Commission Child Obesity page 9-10.
[27] UNDP 2013 Discussion Paper page 14-16, Interim Report Commission Child Obesity page 9.
[28] UNDP 2013 Discussion Paper page 14.
[29] UNDP 2013 Discussion Paper page 13, 15.
[30] FAO and WHO 'Second International Conference on Nutrition' (19-21 November 2014) ICN2 2014/2.
[31] Oliver de Schutter, ' Food democracy South and North: from food sovereignty to transition initiatives' (17 March 2015, Opendemocracy) <https://www.opendemocracy.net> accessed 26 July 2015, Tina D. Beuchelt and Detlef Virchow ' Food sovereignty or the human right to adequate food: which concept serves better as international development policy for global hunger and poverty reduction?'[2012] Agric Hum Values 259.

generation.[32] Laws and policies addressing maternal health, and infant and child nutrition are thus central. Such policies should be adapted where necessary to respond to the physical activity and nutrition transitions.[33]

3 Trade, Law and Health

3.1 International Political Economy and Global Governance

Today, neoliberal free trade is the dominant international political economy. In the 1980s developing states were compelled by the World Bank and International Monetary Fund (IMF) to adopt structural adjustment programs (SAPs) as part of loan conditions. SAPs required developing states to introduce neoliberal free trade by opening their markets, including food markets to other states. This economic paradigm was further consolidated through the World Trade Organisations (WTO) system of international laws, rules and regulations which further integrated markets by removing tariff barriers and non-tariff barriers (NTB) to trade limiting export subsidies and removing domestic protection on food to promote the freer flow of goods and services. One of the goals of these policies was to make the market more efficient in producing the kinds of food people wanted and needed. However, one of the effects of these policies is an increase in the production, availability and accessibility of unhealthy foods over healthy ones, such as the substantial increase in the global production of unhealthy vegetable oils like partially hydrogenated soybean oil, a source of trans-fats. States following market deregulation policies have a faster increase in unhealthy food consumption and mean BMI.[34] The UN Rapporteur on the Right to Health has noted that, a major cause of concern with these policies and laws is the 'critical focus areas of health such as diets and nutrition have not been given due consideration.'[35] Another cause of concern is that the results do not necessarily represent the kind of development sought by developing states. The IMF recently acknowledged the model has failed to accomplish its outcomes and has instead led to even more inequality across the globe.[36]

3.2 Free Trade Agreements

The framework of the WTO has also been used by some states to challenge steps taken in other states to protect public health, such as labelling of nutritional information. For example, Chile's 2013 attempt to label 'junk food' in response to the obesity epidemic among its youth was raised as an NTB before the WTO by other states.[37] Moreover, trade agreements between states facilitate foreign direct investment (FDI).[38] For example, as a result of the 1994 North American Fair Trade Agreement (NAFTA) between Mexico, Canada and the United States of America, foreign companies widely produced, marketed and distributed processed foods in Mexico. There was a sharp rise in consumption of unhealthy foods. Total energy intake from fat increased from 23.5 percent to 30.3 percent between 1988 and 1999. Today more than 8 percent Mexicans have diabetes, predominantly type 2 diabetes. WHO estimates, that diabetes costs the country US$15 billion per year in health expenditure.[39] Investor-state dispute settlement mechanisms (ISDS) are a common dispute resolution feature in investment and some trade agreements. Unlike other legal

[32] Interim Report Commission Child Obesity page 7.
[33] Interim Report Commission Child Obesity page 7, 9.
[34] UN Doc A/HRC/26/31 para 7, UNDP 2013 Discussion Paper page 33.
[35] UN Doc A/HRC/26/31 para 7.
[36] Era Dabla-Norris, Kalpana Kochhar, Nujin Suphaphiphat, Frantisek Ricka and Evridiki Tsounta, 'Causes and Consequences of Income Inequality: A Global Perspective' (*IMF*, 2015) page 4-7.
[37] WTO 'Technical Barriers to Trade: Formal Meeting Members discuss guidelines for trade-friendly regulation and STOP sign for 'junk food'' (13 March 2013, WTO) <www.wto.org> accessed 26 July 2015.
[38] UN Doc A/HRC/26/31 para 8.
[39] UNDP 2013 Discussion Paper page 31-32.

proceedings, binding proceedings and decisions of these dispute resolution mechanisms as a general rule are held in camera and kept under seal. In exceptional circumstances some decisions and aspects of proceedings are placed in the public domain.[40] Unless otherwise specified in a treaty concluded on or after 1 April 2014, in the case of UNICTRAL arbitrations, the Rules of Transparency shall apply.[41] Where a treaty was concluded before 1 April 2014 the Rules of Transparency shall apply only if the parties to the arbitration agree to this or the state parties to the treaty have agreed to such application.[42] The Rules of Transparency mandate publication of certain information in relation to arbitral proceedings.[43] An international treaty extending this and other protections to other ISDS mechanisms opened for signature on 17 March 2015.[44] ISDS matter because when states have intervened to protect the human rights of their people in the face of corporate activity, they have found themselves compelled to justify their actions under the jurisdiction of such bodies.[45] If a state loses an ISDS case, it will usually have to pay a fine.[46] Similar challenges through ISDS provisions may be anticipated to public health measures to address obesity and diabetes.

3.3 Practices of the International Food and Beverage Industry

Through trade agreements, among other mechanisms, major transnational companies (TNCs) in the food and beverage sector have come to dominate food production and distribution in developed and developing countries. These TNCs are active in the retail sector, such as supermarkets and restaurant chains, producers of goods such as manufacturing and processing companies. They also own agricultural businesses such as farming companies and the agrochemical industry, as well as the advertising and media industry harnessed to promote unhealthy foods. TNCs have come to dominate international and domestic trade in food, prioritising unhealthy foods over healthier options. For example, advances in technology have extended the shelf life of processed food, without regard to nutrition content. Finally, aggressive overt and covert marketing tactics exacerbate the situation. For example, the marketing of food and non-alcoholic beverages to children, takes many forms from free toys distributed at fast food outlets, to commercials on television, and via the internet and mobile telephones, amongst other media outlets. These are structural factors contributing to the rise of NCDs which must be addressed in public policy responses to NCDs.

Covert tactics include public relations campaigns such as funding 'front organisations or groups' created to undermine key public health messaging on their products.[47] The Global Energy Balance Network, a global non-profit organisation active in Africa, Asia and Latin America and the Caribbean,

[40] UNCTAD 'IIA Issue Note No. 1 February 2015 Recent Trends in IIAS and ISDS' (*UNCTAD*, 2015), UNGA Resolution 68/109 United Nations Commission on International Trade Law Rules on Transparency in Treaty-based Investor-State Arbitration and Arbitration Rules (as revised in 2010, with new article 1, paragraph 4, as adopted in 2013) (UNGA Resolution 68/09) Article 1 (4) on 16 December 2013 UNICTRAL arbitrators were for the first time internationally obliged to take public interest into account when exercising their discretion.
[41] UNGA Resolution 68/09 Article 1 (1).
[42] UNGA Resolution 68/09 Article 1 (2).
[43] UNGA Resolution 68/09 Article 2, 3.
[44] United Nations Convention on Transparency in Treaty□based Investor-State Arbitration (adopted on 10 December 2014, opened for signature 17 March 2015).
[45] Australian Government Attorney-General's Department ' Tobacco plain packaging—investor-state arbitration' (Australian Government) < http://www.ag.gov.au> accessed 2 August 2015, see the case of Uruguay Jim Armitage ' Big Tobacco puts countries on trial as concerns over TTIP deals mount' (21 October 2014, *The Independent*) <http://www.independent.co.uk> accessed 11 August 2015.
[46] Sanya Reid-Smith, The Hague, 22 September 2015.
[47] UN Doc A/HRC/26/31 para 4-9, 30, Dr Margaret Chan, Director-General of WHO, opening address at the Eighth Global Conference on Health Promotion, Helsinki, 10 June 2013 <http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/> accessed 12 August 2015.

funded in part by Coca-Cola diminishes the role of junk food in obesity, notwithstanding advice from nutritional experts to the contrary.[48] The Alliance for Food and Farming, attempts to persuade consumers by convincing journalists that fruits grown using agrochemicals are just as safe as organic produce.[49] This is contrary to scientific evidence which proves a connection between even low levels of pesticides and cancer. In the USA, farmworkers and their children have higher levels of cancer amongst other NCDs as an outcome of their exposure to certain pesticides used in the agricultural industry.[50]

PART III LESSONS LEARNED FROM THE RIGHT TO HEALTH AND EPIDEMICS

The right to health has played a key role in global public health. The HIV epidemic was the first global health issue to which the international community applied an explicit human rights-based approach. It paved the way for other human rights based responses to global epidemics like tobacco consumption and its ill effects. Given the classification of obesity as a global epidemic, it is fitting to recall lessons learnt from addressing HIV and tobacco epidemics.

4. The Human Rights Based Approach to HIV

The global response to HIV broke new ground in many areas: the first UN multi-agency program on a health issue; the first UN Security Council resolution on a health issue; and the largest amount of annual funding mobilised on any health issue.[51] It is worth considering how the human rights-based approach to HIV evolved, how it contributed to the global response to HIV (politically, programmatically, and financially), and what lessons might be relevant to the global response to NCDs.

4.1 Conception and Development

HIV emerged as a global health challenge during the 1980s. The lack of easy access to a test for HIV infection and the long latency period (from infection to symptomatic illness) meant that standard public health approaches for addressing infectious diseases (identification, isolation, quarantine) were ineffective and inappropriate. Fear of the disease and stigma associated with sex and drug use meant that discrimination against people living with HIV (PLHIV) was also widespread. This included a ban on travel to some countries, even though this could not be justified on public health grounds, as HIV is not transmitted through casual contact. In May 1988, the World Health Assembly (WHA) adopted a resolution noting that respect for human rights was essential for the success of national

[48] Joanna Walters ' Nutrition experts alarmed by nonprofit downplaying role of junk food in obesity' (11 August 2015, The Guardian), see https://gebn.org.
[49] Friends of the Earth, 'Spinning Food How Food Industry Front Groups and Covert Communications Are Shaping the Story of Food' (*Friends of the Earth*, 2015) (Friends of the Earth 2015) page 13-14, 16.
[50] President's Cancer Panel 'Reducing Environmental Cancer Risk What We Can Do Now 2008-2009 Annual Report' 2010 US Department of Health and Human Services, National Institute of Health and National Cancer Institute page iii, iv, vi, xvi, xx, 5, 16, 38, 43-47, 56, Friends of the Earth 2015 Report page 13-14, 16, World Health Organization Regional Office for Africa 'Chemicals of public health concern in the African Region and their management Regional Assessment Report' (WHO Regional Office for Africa, 2014) page 5, 32-36.
[51] See e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria (www.theglobalfund.org) and President's Emergency Fund for AIDS Relief (PEPFAR) (www.pepfar.gov) (accessed 4 August 2015).

AIDS programmes, and urging States to avoid discriminatory actions in the provision of services, employment and travel.[52]

In July 1989, the first international consultation on AIDS and human rights was organized by the (then) United Nations Centre for Human Rights and the WHO Global Programme on AIDS (WHO/GPA). In 1990, WHO conducted regional workshops on the legal and ethical aspects of HIV and AIDS in Seoul, Brazzaville and New Delhi. From 1989, the (then) UN Sub-Commission on the Prevention of Discrimination and Protection of Minorities adopted annual resolutions on discrimination against people living with HIV. The Special Rapporteur of the UN Sub-Commission presented reports to the Sub-Commission between 1990 and 1993. The UN General Assembly adopted resolutions on HIV/AIDS in 1990 and 1991. From 1990, the (then) UN Commission on Human Rights adopted resolutions on human rights and HIV at its annual sessions. These resolutions affirmed that discrimination on the basis of HIV/AIDS status [sic], actual or presumed is prohibited by existing international human rights standards and clarify that the term 'or other status' used in non-discriminatory clauses of such texts 'should be interpreted to include health status, such as HIV/AIDS.'[53] In May 1992 the WHA adopted a resolution recognizing that there is no public health rationale for measure which arbitrarily limit individual rights, such as mandatory screening.[54]

In September 1996, UNAIDS and the Office of the High Commissioner for Human Rights hosted the Second International Consultation on HIV/AIDS and Human Rights. The consultation produced the 'International Guidelines on HIV/AIDS and Human Rights' (Guidelines). The Guidelines are 12 short principles which distil the application of international human rights law to HIV and AIDS (see Annex 2). The Guidelines are based on concrete and substantive legal principles, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), Art. 12. They clarify the application of these principles within a domestic legal system to respect, protect and fulfil right to health obligations, such as through civil, criminal and administrative law. For example, the right to equality clearly protects PLHIV from discrimination in public and private spaces such as in the area of employment law. Whilst the Guidelines focus on the primary role of the state, attention is also paid to the responsibilities of private actors in the healthcare sector, from healthcare professionals through to corporate insurers of health services. The role of the international community through the legal principle of international cooperation and assistance is also noted. The report of the Second International Consultation on HIV/AIDS and Human Rights also contains comprehensive explanatory notes on how States should apply the Guidelines in practice. The report was translated in to all six UN languages and disseminated widely.[55]

4.2 Dissemination and Integration

In 1997 the Commission on Human Rights 'took note' of the report of the Consultation, and adopted a resolution reflecting the content of the Guidelines.[56] Similar resolutions were adopted by the Commission in subsequent years, thus consolidating the human rights-based response to HIV and AIDS. Subsequent resolutions of the Commission (1999/49 and 2001/51) asked states to report on measures taken, where appropriate, to promote and implement the Guidelines. Many States did so, and the subsequent reports to the Commission generated further momentum for the

[52] WHA 41.24 'Avoidance of discrimination in relation to HIV-infected people and people with AIDS', 13 May 1988.
[53] Commission on Human Rights Resolutions 1990/65, 1992/56, 1993/53, 1994/3=49, 1995/44, 1996/43.
[54] WHO 45.35, 14 May 1992.
[55] Due to the global spread of HIV and the breakthroughs in treatment, in 2002 the Third International Consultation on HIV/AIDS and Human Rights updated Guideline 6, including State obligations regarding access to treatments for HIV and AIDS. A consolidated version was published in 2006.
[56] The Guidelines were annexed to UN Commission on Human Rights resolution 1997/33.

implementation of the Guidelines. The Inter-Parliamentary Union and UNAIDS published two editions (1999, 2007) of a handbook for legislators based on the Guidelines – these were disseminated in English, French and Spanish.[57] Also in 1999, the International Council of AIDS Service Organizations (ICASO) published a civil society advocacy guide for the Guidelines in English, French and Spanish.[58] In 2001, UNESCO and UNAIDS published 'HIV/AIDS and Human Rights; Young People in Action', which incorporated the International Guidelines on HIV/AIDS and Human Rights. In 2001, the UN General Assembly held the first ever Special Session on a health issue, and adopted the 'Declaration of Commitment on HIV/AIDS.'[59] The Declaration did not reference the Guidelines directly, but included references to human rights throughout the text. In 2006 and 2011, the UNGA held high level meetings on HIV/AIDS, and issued 'Political Declarations' which reflected and extended the earlier commitments to address the human rights of PLHIV and key affected populations.

4.3 Monitoring and Resource Mobilization

In 2002 UNAIDS developed indicators for monitoring the progress in implementing the Declaration of Commitment. These included global and national level indicators, and included a 'national composite policy index' with an explicit reference to the human rights of PLHIV, workplace discrimination, and women and girls affected or at-risk of HIV infection. UNAIDS posted country reports on the implementation of the Declaration of Commitment on its website – a global first – and gave a link to shadow reports on the ICASO website. The UNAIDS Core Indicators have been periodically updated and now contains the National Commitments and Policies Instrument to measure States human rights compliance in the context of HIV and AIDS. The human rights-based approach to HIV and AIDS has been incorporated into the guiding documents of global institutions providing technical and financial resources for the global response to HIV and AIDS. Since its inception in 1996, UNAIDS has held human rights and gender as cross-cutting themes. The Global Fund to Fight AIDS, Tuberculosis and Malaria adopted human rights as one of five pillars of its Strategy Framework 2012-2016. The US President's Emergency Fund for AIDS Relief (PEPFAR) has also adopted human rights as one of its six core agendas.

5 The Framework Convention on Tobacco Control

In 2003 the WHO Member States adopted the Framework Convention on Tobacco Control (FCTC).[60] Tobacco products are scientifically proven to cause harm to human health, leading to disability and death. Moreover, tobacco products are created to ensure dependency on account of certain ingredients in these products that are pharmacologically active, toxic, mutagenic and carcinogenic. Tobacco products affect the smoker and others around them exposed to tobacco smoke. In pregnant women, tobacco impairs the health of the foetus. Rapid increases in smoking among women, indigenous people and children were also a major cause for concern.[61] Thus, the aim of the treaty was to address causes of the epidemic, 'including complex factors with cross-border effects,

[57] UNAIDS and Inter-Parliamentary Union, *Handbook for legislators on HIV/AIDS, law and human rights* (Geneva: UNAIDS, 1999); UNAIDS, Inter-Parliamentary Union and UNDP*, Taking Action against HIV* (Geneva: UNAIDS, 2007).
[58] International Council of AIDS Service Organizations (ICASO). *An advocate's guide to the international guidelines on HIV/AIDS and human rights* (Toronto: ICASO, 1999.)
[59] UNGA 'Declaration of Commitment on HIV/AIDS' (27 June 2001) UN Doc A/Res/S-26/2.
[60] WHO FCTC 'The WHO Framework Convention on Tobacco Control: an overview' (*WHO FCTC*, 2015) (FCTC Overview) page 1.
[61] WHO Framework Convention on Tobacco Control 2302 UNTS 166 (adopted 21 May 2003, entry into force 27 February 2005) (FCTC) Preamble.

such as trade liberalization and direct foreign investment, tobacco advertising, promotion and sponsorship beyond national borders, and illicit trade in tobacco products.'[62] To accomplish this, the treaty clearly defined relevant terms,[63] outlined objectives, guiding principles and general obligations,[64] stipulated interventions on measures to reduce demand and supply[65] and also addressed measures such as environmental health,[66] appropriate liability,[67] dispute settlement measures[68] amongst others all from which lessons may be derived. Such as on:

5.1 The objectives of the treaty are to protect present and future generations from the devastating health, socio-economic and environmental effects of tobacco consumption and exposure to tobacco smoke through measures implemented domestically, regionally and internationally.[69]

5.2 Guiding principles that clearly articulate substantive rights and mechanisms for protection and implementation, for example, everyone has a right to be informed of the harmful effects of tobacco consumption and exposure. In relation to implementation, states are required to:

5.2.1 Contemplate appropriate legislation, administrative and executive measures to protect people from exposure to tobacco smoke;[70]

5.2.2 Adopt a multisectoral approach, based on a number of considerations, such as targeted interventions aimed at addressing exposure to smoke, smoking initiation and cessation, include participation of affected groups namely indigenous people[71] and civil society[72] when framing and implementing interventions and include gender-specific interventions.[73]

5.2.3 Moreover, obliges states to develop a national strategy, plan and programmes to tackle the tobacco epidemic in keeping with this principle;[74]

5.2.4 Mandates international cooperation on key things such as knowledge and technology transfer and financial assistance;[75] and

5.2.5 Define and assign liability within its jurisdiction.[76]

5.3 General obligations clearly designed to support the guiding principles such as in areas of developing a national framework based on a multisectoral approach and aspects in relation to

[62] FCTC Overview page 2.
[63] FCTC Article 1.
[64] FCTC Part II.
[65] FCTC Part III.
[66] FCTC Part V.
[67] FCTC Part VI.
[68] FCTC Part IX-X.
[69] FCTC Article 3.
[70] FCTC Article 4 (1).
[71] FCTC Article 4 (2) and 4 (4).
[72] FCTC Article 4 (7).
[73] FCTC Article 4 (2) and 4 (4).
[74] FCTC Article 5 (1).
[75] FCTC Article 4 (3), 4 (6), 5 (5), 5 (6).
[76] FCTC Article 4 (5).

international cooperation[77] and the inclusion of a protective stipulation that in, 'setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.'[78]

5.4 Specific interventions to reduce the demand of tobacco products cover price and non-price measures, exposure to smoke in work places and other public places, content of tobacco products and their emissions, packaging and labelling of tobacco products, education and raising public awareness, promotion and advertising of tobacco products and measures to reduce tobacco dependence and increase tobacco cessation.[79]

5.5 On the supply side interventions addressed elimination of illicit trade in tobacco, prohibition on sale of tobacco to persons below 18 years and support measures to promote economically viable alternatives for those previously in the tobacco trade, such as farm workers.[80]

5.6 Liability states are required to consider instituting civil and criminal liability where appropriate depending on existing laws. Moreover, states shall share such information with each other and provide assistance to one another as appropriate.[81] It is highlighted that implementation, 'of Article 19 presents Parties with an opportunity to collaborate in their efforts to hold the tobacco industry liable for its abuses. The importance of liability as part of comprehensive tobacco control is also recognized in Article 4.5.'[82]

The experience of the FCTC and the global response to tobacco have demonstrated the need for national capacity in international law (health, human rights, trade, and investment law), a strong evidence based, and an informed and mobilized civil society.

PART IV ARTICULATING AN INTERNATIONAL HUMAN RIGHTS LAW FRAMEWORK FOR NCDS

As noted above, issues at this meeting are examined in depth with reference to obesity, diabetes and healthy diets. The conclusions, however, will contain lessons for other NCDs. Consistent with this, Part IV sets out elements relevant to articulating a human rights-based approach to NCDs. It considers, the right to health, healthcare including access to medicine, underlying determinants of health and the rights of the child.

6. The Right to Health

The right to health in Article 12 ICESCR is , 'understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable

[77] FCTC Article 5.
[78] FCTC Article 5 (3).
[79] FCTC Article 6-14.
[80] FCTC Article 15-17.
[81] FCTC Article 19.
[82] FCTC Overview page 5.

standard of health'.[83] It comprises freedoms and entitlements. A freedom is the right to control one's health and body. An entitlement is the 'right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health'.[84] The right to health is a holistic right.[85] It encompasses timely and appropriate health care and underlying determinants of health like food.[86]Each of its elements is relevant to articulating a human rights framework in response to NCDs. In the case of obesity states are required 'to take measures to prevent diet-related NCDs and provide equal and timely access to primary health care'.[87] This obligation flows from Article 12 (2) (c) ICESCR which provides for a right to prevention, treatment and control of diseases,[88] and Article 12 (2) (d) ICESCR which provides for the right to health facilities, goods and services.[89]

6.1 Timely and Appropriate Health Care

In terms of the right to treatment of diseases, the state is required to establish a system of urgent medical care to respond to epidemics, accidents and other health hazards.[90] In regard to the right to control of diseases the state is required to work individually and in cooperation with others to make relevant technology available, use and improve epidemiological surveillance amongst other strategies to control diseases.[91] The right to health facilities, goods and services requires the state to create 'conditions which would assure to all medical services and medical attention in the event of sickness'.[92] The state is required to provide for physical and mental health, ensuring equal and timely access to care for basic preventative, curative and rehabilitative health services. The state should also provide appropriate treatment of prevalent diseases, including the provision of access to essential medicine.[93] Discrimination in access to health care, and means and entitlement of health care procurement is expressly proscribed.[94] To prevent discrimination states are explicitly obliged to provide for the health care needs of those with insufficient means, such as through health insurance and health care facilities, and especially in regard to core right to health obligations.[95] It is also required to further and improve the participation of the population in the provision of preventative and curative health services, including the process of making political decisions on health at the community and national level.[96]

6.1.1 Access to Medicine

The right to access medicine flows from the entitlements under the right to health to a system of health protection capable of providing equal access to affordable, safe and quality medicine, and

[83] UN Committee on Economic, Social and Cultural Rights 'General Comment 14' (11 August 2000) UN Doc E/C.12/2000/4 (General Comment 14) para 9.
[84] General Comment 14 para 8.
[85] General Comment 14 para 7, 10-11, 13 it is also instructive to note Article 12 (2) is understood as enumerating a non-exhaustive list illustrating state obligations.
[86] General Comment 14 para 10-11.
[87] UN Doc A/HRC/26/31 para 13.
[88] General Comment 14 para 16.
[89] General Comment 14 para 17.
[90] International Covenant on Economic Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) Article 12 (2) (c), General Comment 14 para 16.
[91] ICESCR Article 12 (2) (c), General Comment 14 para 16.
[92] ICESCR Article 12 (2) (d), General Comment 14 para 17.
[93] ICESCR Article 12 (2) (d), General Comment 14 para 17.
[94] General Comment 14 para 18, see also para 20-27.
[95] General Comment 14 para 19, see also para 30 preventing discrimination is an immediate obligation.
[96] ICESCR Article 12 (2) (d), General Comment 14 para 17.

from the specific entitlement to essential medicine.[97] The right to medicine is also implied by other rights, such as the right to life and freedom from torture. [98]

The entitlement to access medicine mandates safe, efficacious and quality medicine of sufficient quantity, and includes pain medication for palliative care. In terms of the relationship between the right to health and other human rights this entitlement also extends to a system that ensures research and development into new medicine on public health priorities.[99] Key supporting rights for such a system are the right to science and the right to development.[100] The Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicine add to the human rights framework in this respect.[101]

One of the recent challenges to access was the narrow interpretation of the patent protections provided by the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). For example, the first antiretroviral treatments for HIV cost US$10 000 per person per year, outpricing access for many people in developed and developing countries. This was possible because the pharmaceutical manufacturer could price medicine as they intended given their intellectual property over it.[102] The situation was improved following the adoption of the Doha Declaration on the TRIPS Agreement and Public Health, which confirmed pre-existing rights of states to use the so-called TRIPS flexibilities. These flexibilities include a range of measures, the most notable being issuance of a compulsory license. A government issued compulsory license makes it possible for other manufacturers to import, produce and distribute a generic version equivalent in quality, safety and efficacy to the patented medicine.[103] This has the effect of significantly reducing the price of medicine and greatly increasing accessibility.

Access to NCD medication is subject to similar challenges as those experienced in the area of HIV/AIDs medicine. Increasingly WHO includes new NCD medication on the Model List of Essential Medicines. In 2015 cancer medicines *imatinib* and *trastuzumab* were added to the list.[104] However, most new NCD medicine remains unaffordable for most in developed and developing countries. In Malawi patients pay for their own medicine and a one month course of CVD medicine costs 18 days wages.[105] States experience challenges when attempting to issue compulsory licenses over NCD

[97] ICESCR Article 12, General Comment 14 para 8, 9, 17, 43 (d), UN HRC 'resolution 23/… Access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (11 June 2013) UN Doc A/HRC/23/L.10/Rev.1 (UN HRC Res 23 Access to Medicine) para 1-6.
[98] Noah Novogrodsky,"The Duty of Treatment: Human Rights and the HIV/AIDs pandemic"[2009] Yale Hum. Rts. & Dev. L.J. 1 page 55-56, UNCHR 'Report of the Special Rapporteur on Torture and Other Cruel, inhuman or degrading treatments or punishment, Manfred Nowak' (2009) UN Doc A/HRC/10/44 para 57-62,68-74 argues denial of treatment for drug addiction, HIV/AIDs and palliative care can amount to torture in certain circumstances.
[99] ICESCR Article 12, General Comment 14 para 12 (a), 13, UN HRC Res 23 Access to Medicine para 3, 5, WHO Access to Controlled Essential Medicine page 11-12.
[100] UDHR Article 27, ICESCR Article 15, UNGA ' Declaration on the Right to Development' (4 December 1986) UN Doc A/RES/41/128 Article 8.
[101] UNHRC 'Report to the General Assembly of the UN Rapporteur on the right to the highest attainable standard of health Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicine' (11 August 2008) UN Doc A/63/263.
[102] Holger Hestermeyer, *Human Rights and the WTO: The Case of Patents and Access to Medicines* (OUP 2007) page 5-6.
[103] Declaration on the TRIPS Agreement and Public Health (14 November 2001) WT/MIN(01)DEC/W/2 <http://docsonline.wto.org> .
[104] WHO 'WHO Model List of Essential Medicines 19th List As Amended June 2015(*WHO*, 2015) page 22, 23.
[105] Sandeep P. Kishore, Rajesh Vedanthan and Valentin Fuster ' Promoting Global Cardiovascular Health

medication. In 2007 Thailand issued compulsory licenses on AIDS drug lopinavir/ritonavir. Abbot the pharmaceutical company holding the patent over lopinavir/ritonavir responded by withdrawing new drug applications from the Thai Drug and Food Administration. The first batch of drugs was received by Thai State hospitals in 2008 following a public outcry from national and international activists. However, this experience has affected Thailand's efforts to source non AIDS essential drugs such as cancer medication through compulsory licensing.[106]

These similarities in experience reaffirm the value of the political commitment in SDG 3.b to apply TRIPS flexibilities in the area of NCD medicine. This also reinforces the UN HRC Resolution on Access to Medicine.[107] Another problem illustrated in the area of palliative care is lack of access to opioid analgesics like morphine, an inexpensive controlled substance indispensable for treatment of moderate to severe pain in cancer and HIV/AIDs patients.[108] It is estimated 5.5 million terminal cancer patients 'suffer disease, moderate to severe pain and ultimately death due to not having access to controlled medicines'.[109] An estimated 80% globally lack access to morphine for pain relief.[110] Barriers to accessing controlled essential medicines like morphine result from international and domestic law and policy, economic and social factors.[111] Finally, most developing countries source their medicine from India, where this role is under continuing high level and other pressure.[112] Moreover, the Doha Declaration reflects a commitment to promote the capacity of developing states to produce their own medicine, which has not yet been sufficiently explored.

6.2 Food and Nutrition Security

In the case of obesity, the underlying determinants of health include the separate concepts of food and nutrition security. Food security is 'the situation where “all people, at all times, have physical and economic access to sufficient, safe and nutritious food necessary to meet their dietary needs and food preferences for an active and healthy life”'.[113] Moreover, the Committee on Economic, Social and Cultural Rights has observed, “[e]very State is obliged to ensure for everyone under its jurisdiction access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger”.[114]

Ensuring Access to Essential Cardiovascular Medicines in Low- and Middle-Income Countries' [2011] Journal of the American College of Cardiology 1980 page 1980-1981.

[106] Ellen t'Hoen *The Global Politics of Pharmaceutical Monopoly Power* (AMB 2009) page 47-50, 86-87, Sean Flynn, 'Thailand's Lawful Compulsory Licensing and Abbott's Anticompetitive Response Memo' *American University Washington DC* (Washington DC, 26 April 2007) <https://www.wcl.american.edu/pijip/> accessed 1 June 2015 page 1-2; Program on Information Justice and Intellectual Property, ' Timeline for US-Thailand Compulsory License Dispute Version 3, April 2009' *Program on Information Justice and Intellectual Property* (Washington DC, April 2009) <http://infojustice.org> accessed 1 June 2015.

[107] UNHRC Res 23 Access to Medicine para 3, 5.

[108] WHO 'Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines' (*WHO*, 2011) (WHO Access to Controlled Essential Medicine) page 13-14.

[109] WHO Access to Controlled Essential Medicine page 4.

[110] WHO Access to Controlled Essential Medicine page 4.

[111] WHO Access to Controlled Essential Medicine page 5, 16, Allyn L. Taylor ' Addressing the Global Tragedy of Needless Pain: Rethinking the United Nations Single Convention on Narcotic Drugs' [2007] Journal of Law, Medicine & Ethics 556 page 557-559.

[112] Anand Grover, ' After a decade: why we need to protect Section 3(d) of the patent law' (3 April 2015, *The Hindu BusinessLine*)<http://www.thehindubusinessline.com> accessed 18 April 2015, Medicins Sans Frontrieres ' A Timeline of U.S. Attacks on India's Patent Law & Generic Competition' (2015, MSF) <http://www.msfaccess.org/> accessed 2 August 2015.

[113] UN Doc A/HRC/26/31 para 1,12

[114] UN Doc A/HRC/26/31 para 1,12.

To progressively realise this right states should develop time-bound plans which include both immediate and continuous action within the maximum of their available resources; such as the formulation of health policies applicable to trade, agriculture and the food industry.[115] States should also adopt legislation and national health policies detailing plans for the realisation of the right.[116] Other elements worth highlighting include the state obligations in relation to international cooperation in terms of the right to health.[117]

6.2.1 The States Duty to Respect, Protect and Fulfil

6.2.1.1 The obligation to respect the right to health is a negative duty of the State to refrain from interfering with people's enjoyment of their right to health. It recognizes the right and autonomy of individuals to make informed decisions with respect to their health.'[118] It also requires states to engage with laws and policies concerning the food industry.[119] One method of accomplishing this is to provide members of the public with accurate food information through national guidelines. An illustration of this is to adopt a nutrient profiling model, which ranks different foods according to nutritional composition. States are also obliged to engage and make laws and policies for the food industry to ensure the availability and accessibility of healthy food options for the individual to choose from. This can be accomplished through education and public awareness campaigns. Consumer friendly food labelling is one common approach demonstrating this. Other measures states can take include a range of fiscal policies designed to reduce availability of unhealthy food and increase accessibility of healthy food. Subsidising fruit and vegetables and withdrawing subsidies from unhealthy food is one such approach.[120]

6.2.1.2 The UN Rapporteur on the Right to Health also notes that States have the obligation to protect people from violations of their right to health from the activities of non-State actors. The state is obliged to protect individuals from the practices of the food industry such as by ensuring corporate promotion and advertising of food products includes clear and accurate information about the ill health effects of their products. They can accomplish this through a range of policy and legislative measures. Some states have accepted industry led voluntary measures, like those aimed at protecting children. Studies show voluntary measures have had no significant impact on aggressive marketing strategies. Also companies circumvent some of these measures due to various factors including their nonbinding nature. Another approach followed is public private partnerships between states and food corporations. Difficulties associated with this approach include conflict of interest, lack of transparency and independence of regulators. Given this in keeping with the states obligation to protect, particularly as it pertains to vulnerable groups, states should enact legislation to prevent companies from

[115] UN Doc A/HRC/26/31 para 13.
[116] General Comment 14 para 36; Text para 6, 6.1.
[117] General Comment 14 para 38-42; Text para 6, 6.1.
[118] UN Doc A/HRC/26/31 para 14.
[119] UN Doc A/HRC/26/31 para 14.
[120] UN Doc A/HRC/26/31para 14, 17-21.

using insidious marketing strategies. States may regulate FDI such as by requiring supermarket chains to provide healthy foods in their stores among other strategies given imposing conditions might serve as a disincentive on investors to invest.[121]

6.2.1.3 Finally, the UN Rapporteur on the Right to Health notes that fulfilling the right to health is a positive obligation that requires States to adopt a national public health strategy and plan of action to achieving the highest attainable standard of health. In the context of healthy diets and physical activity, this includes state provision of accurate information about food to aid informed decision making by the public. Also states should enact policies and legislation to make sure healthy food options are available and accessible. This may include changing food and agricultural, trade and fiscal policies. At the same time it should be framed in such a way so as not to hinder production from small scale farmers.[122] It must also be noted in regard to a core obligation, to ensure equality of access for those without means states should ensure 'access to the minimum essential food which is nutritionally adequate and safe'.[123]

6.2.2 Responsibilities of the Food and Beverage Industry

The UN Rapporteur on the Right to Health noted that the 'International Covenant on Economic, Social and Cultural Rights prohibits the violation of human rights enshrined therein not only by States, but also by any "group or person", clearly implicating the responsibility of non-State actors in the realization of human rights (article 5)'.[124] This is consistent with human rights guidelines, such as the Guiding Principles on Business and Human Rights, which have clarified that corporations have a responsibility to respect human rights like the right to health.[125] The responsibility to respect broadly requires food industries to refrain from activities that negatively impact the right to health.[126] The food industry must comply with state legislation and policy enacted to encourage consumption of healthy diets and discourage consumption of unhealthy food. They should also take measures to prevent, mitigate and remedy harmful effects of their activities. In accordance with national laws and regulation they should not advertise unhealthy foods to children given the harm caused to them.[127] They should also stop promoting false or misleading claims about the impact of their products on health, particularly as health benefits about their food claims have often been shown to be unverifiable and deceptive.[128] The food industry can improve the nutritional quality of food by reformulating products, properly labelling food and providing appropriate information on food products to contribute to healthier diets. They should conduct research to improve the nutritional content of food rather than promoting existing products amongst other activities.[129]

[121] UN Doc A/HRC/26/31para 22-27.
[122] UN Doc A/HRC/26/31para 16.
[123] General Comment 14 para 18, 19, 43 (b), UN Doc A/HRC/26/31 para 12, 13.
[124] UN Doc A/HRC/26/31para 28.
[125] UN 'Guiding Principles on Business and Human Rights' 16 June 2011 UN Doc HR/PUB/11/04 (Guiding Principles on Business and Human Rights), UN Doc A/HRC/26/31 para 28.
[126] Guiding Principles on Business and Human Rights Principle A.11, UN Doc A/HRC/26/31 para 29.
[127] Guiding Principles on Business and Human Rights Principle A.11, UN Doc A/HRC/26/31 para 29, Interim Report Commission Child Obesity page 5, 8, 14-16.
[128] UN Doc A/HRC/26/31 para 29-30.
[129] UN Doc A/HRC/26/31 para 31-32.

6.3 The Rights of the Child to Health and Food

Children are entitled to Article 12 ICESCR protection in addition to the Convention on the Rights of the Child (CRC).[130] Relevant CRC rights worth highlighting in the context of obesity are the best interests of the child in all actions undertaken concerning children,[131]states obligation to ensure all institutions, services and facilities responsible for the care of children respect a child's rights including health,[132]obligation on the state to implement the treaty using all measures, legislative and administrative including its available resources in the case of ESCRs,[133] the child's right to access information from all sources in particular on aspects affecting their health and well-being,[134] recognition and promotion of the principle that both parents have a common responsibility for the upbringing and development of the child,[135] rights of the disabled child,[136] the right to health of the child which includes provision of adequate nutritious food, prenatal and postnatal care for the mother and access to treatment,[137] right of the child to an adequate standard of living including nutrition[138] and the rights of a child to an education[139] which obliges states to provide education directed to, 'development of the child's personality, talents and mental and physical abilities to their fullest potential'.[140] Private educational institutions are also obliged to respect provisions of CRC Article 29 (1) (a).[141] The CRC is endorsed in the interim report of the WHO Commission on Ending Childhood Obesity, which proposes basing policy on its provisions, amongst other human rights, such as women's rights.[142]

7. Draft Treaties Relevant to a Framework on Human Rights and NCDs

In response to concerns about the rapid global increase in obesity and diabetes, linked largely to poor diets, civil society organizations have drafted a 'global convention to protect and promote healthy diets.' The draft includes a clear obligation to inform everyone about the health, social and economic consequences of poor diets and the requirements of a healthy diet. To accomplish this among other goals, the drafters identified three aspects for policy intervention; in particular, the kind of food offered, the price that is paid for it, and how it is marketed and promoted. [143] The Joint Action and Learning Initiative propose a Framework Convention on Global Health. A public platform has been established to develop a broader treaty which includes considerations of trade and intellectual property relevant to human rights and NCDs amongst other key features.[144] Finally, in

[130] Convention on the Rights of the Child 1577 UNTS 3 (adopted 20 November 1989, entry into force 2 September 1990) (CRC); General Comment 14 para 14, 22-24.
[131] CRC Article 3 (1), General Comment 14 para 24.
[132] CRC Article 3 (3).
[133] CRC Article 4.
[134] CRC Article 17, General Comment 14 para 14, 22-23.
[135] CRC Article 18.
[136] CRC Article 23.
[137] CRC Article 24, General Comment 14 para 14, 22.
[138] CRC Article 27.
[139] CRC Article 28.
[140] CRC Article 29 (1) (a).
[141] CRC Article 29 (2).
[142] Interim Report Childhood Obesity page 10,19; Interim Report Commission Child Obesity page 24 they recommend an accountability framework and note the Director-General of WHO established an Ad hoc Working Group on Implementation, Monitoring and Accountability for Ending Childhood Obesity(WGIMA); General Comment 14 para 14.
[143] Consumers International and World Obesity, 'Recommendations towards a Global Convention to protect and promote healthy diets' (*Consumers International and World Obesity*, 2014).
[144] http://jalihealth.org/, http://www.globalhealthtreaty.org/.

terms of Human Rights Council Resolution 26/9 an intergovernmental working group has been convened to elaborate on an international legally binding instrument on transnational corporations and other business enterprises and human rights. Consistent with Resolution 26/9 work has already commenced to elaborate on content, scope, nature and form of the future international instrument.[145]

PART V CONCLUSION

The inclusion of NCDs in the SDG agenda is welcome and reflects a clear international political commitment to address the devastating effects of NCDs on human health and development. This is also consistent with state obligations in relation to international human rights law. The principles which should guide a human rights based approach to global epidemics have been developed and refined since the onset of HIV. Key lessons include the importance of clarifying what a human rights based response means in practical terms for states, the importance of disseminating and explaining these obligations to all stakeholders, and finally, the importance of monitoring progress in the implementation of the obligations to prevent, treat and control epidemics.

The global response to tobacco adds an additional layer to this framework by clearly articulating substantive rights, duties and implementing mechanisms. Finally, elements of the right to health, including the rights of the child are critical to articulating a human rights framework in response to NCDs. Obesity and diabetes, like HIV, are not mentioned explicitly in any international human rights treaty. Nonetheless, there is a wealth of applicable international law regarding state obligations to prevent, treat and control obesity and diabetes and promote healthy diets and physical activity. Non state actors are implicated in relation to their roles and activities. A specific legal instrument to promote and protect healthy diets would further clarify these obligations.

[145] UNHRC Resolution 26/9 'Elaboration of an international legally binding instrument on transnational corporations and other business enterprises with respect to human rights' (14 July 2014) UN Doc A/HRC/RES/26/9, http://www.ohchr.org/EN/HRBodies/HRC/WGTransCorp/Pages/IGWGOnTNC.aspx.

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Annex 1 – Draft Health and Food SDGs[146]

A. FOOD GOALS

Goal 2 End hunger, achieve food security and improved nutrition and promote sustainable agriculture

2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round

2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

2.3 By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment

2.4 By 2030, ensure sustainable food production systems and implement resilient agricultural practices that increase productivity and production, that help maintain ecosystems, that strengthen capacity for adaptation to climate change, extreme weather, drought, flooding and other disasters and that progressively improve land and soil quality

2.5 By 2020, maintain the genetic diversity of seeds, cultivated plants and farmed and domesticated animals and their related wild species, including through soundly managed and diversified seed and plant banks at the national, regional and international levels, and promote access to and fair and equitable sharing of benefits arising from the utilization of genetic resources and associated traditional knowledge, as internationally agreed

2.a Increase investment, including through enhanced international cooperation, in rural infrastructure, agricultural research and extension services, technology development and plant and livestock gene banks in order to enhance agricultural productive capacity in developing countries, in particular least developed countries

2.b Correct and prevent trade restrictions and distortions in world agricultural markets, including through the parallel elimination of all forms of agricultural export subsidies and all export measures with equivalent effect, in accordance with the mandate of the Doha Development Round

2.c Adopt measures to ensure the proper functioning of food commodity markets and their derivatives and facilitate timely access to market information, including on food reserves, in order to help limit extreme food price volatility

Goal 6. Ensure availability and sustainable management of water and sanitation for all

6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all

Goal 12 Ensure sustainable consumption and production patterns

12.1 Implement the 10-Year Framework of Programmes on Sustainable Consumption and Production Patterns, all countries taking action, with developed countries taking the lead, taking into account the development and capabilities of developing countries

12.3 By 2030, halve per capita global food waste at the retail and consumer levels and reduce food losses along production and supply chains, including post-harvest losses

12.6 Encourage companies, especially large and transnational companies, to adopt sustainable practices and to integrate sustainability information into their reporting cycle

12.7 Promote public procurement practices that are sustainable, in accordance with national policies and priorities

12.a Support developing countries to strengthen their scientific and technological capacity to move towards more sustainable patterns of consumption and production

B. HEALTH GOALS

Goal 3 Ensure healthy lives and promote well-being for all at all ages

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

[146] UN Doc A/69/L.85 pages 15-28.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

C. OTHER RELEVANT GOALS

Goal 5. Achieve gender equality and empower all women and girls
5.1 End all forms of discrimination against all women and girls everywhere

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable
11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities

Goal 16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all
16.6 Develop effective, accountable and transparent institutions at all levels
16.7 Ensure responsive, inclusive, participatory and representative decision-making at all levels
16.8 Broaden and strengthen the participation of developing countries in the institutions of global governance
16.10 Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements
16.b Promote and enforce non-discriminatory laws and policies for sustainable development

Goal 17 Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development
17.1 Strengthen domestic resource mobilization, including through international support to developing countries, to improve domestic capacity for tax and other revenue collection
17.6 Enhance North-South, South-South and triangular regional and international cooperation on and access to science, technology and innovation and enhance knowledge sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism

Annex 2 –International Guidelines on HIV/AIDS and Human Rights (1996, as amended in 2002)

GUIDELINE 1: States should establish an effective national framework for their response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

GUIDELINE 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

GUIDELINE 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

GUIDELINE 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

GUIDELINE 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6: (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

GUIDELINE 7: States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

GUIDELINE 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

GUIDELINE 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

GUIDELINE 10: States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

GUIDELINE 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

GUIDELINE 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

Annex 3 – Report of the UN Special Rapporteur on the Right to Health: unhealthy foods, NCDs and the right to health

Conclusions and recommendations[147]

63. In keeping with their obligations to respect, protect and fulfil the right to health, States should formulate and implement a national public health strategy and plan of action to address diet-related NCDs, which should be widely disseminated. Such a strategy should recognize the link between unhealthy foods and NCDs, while specifically addressing the structural flaws in food production, marketing and retail that promote the availability and accessibility of unhealthy foods over healthier options. Towards this end, States should necessarily develop multisectoral approaches that include all relevant ministries such as ministries of health, agriculture, finance, industry and trade. States should also ensure meaningful and effective participation of affected communities such as farmers and vulnerable groups like children, women and low-income groups in all levels of decision-making to discourage production and consumption of unhealthy foods and promote the availability and accessibility of healthier food options.

64. With a view to respecting, protecting and fulfilling the right to health, the Special Rapporteur recommends that States take the following steps:

(a) Increase availability and accessibility of healthier food alternatives through fiscal and agricultural policies that discourage production of unhealthy foods. Also take measures to incentivize farmers to grow healthier products;

(b) Make nutritious and healthy foods available and geographically and economically accessible, especially to low-income groups;

(c) Provide information about the ill effects of unhealthy foods and raise awareness of the benefits of balanced diets and healthy foods to promote consumption of healthier foods; A/HRC/26/31

(d) Adopt, implement and enforce easy-to-understand labelling and nutritional profiling requirements, such as "traffic light" labelling;

(e) Encourage TNCs, through incentives and other fiscal measures, to manufacture and sell healthier alternatives of foods and beverages that are not harmful to the people's health;

(f) Regulate the marketing, advertisement and promotion of unhealthy foods, particularly to women and children, to reduce their visibility and to increase the visibility of healthier options by, for instance, requiring supermarkets to place fruits and vegetables in more accessible and visible places.

65. With a view to ensuring their obligation to realize the right to health of vulnerable groups such as children, women and low-income groups, the Special Rapporteur recommends that States take the following steps:

(a) Address gender stereotypes in preparation of meals that place an unequal burden of cooking on women;

(b) Formulate and implement health education programmes to promote healthy food options in such institutional settings as schools, health or youth centres and workplaces by involving children, parents and employees, respectively;

(c) Ensure that social welfare schemes for low-income groups make relevant information available and provide access to healthier food options to eliminate "food deserts".

66. Recognizing the role of the food industry in the growing burden of NCDs, the Special Rapporteur recommends that the food industry take the following steps:

(a) Adopt internationally acceptable nutritional labelling guidelines and comply with domestically-enacted guidelines in this respect;

(b) Refrain from marketing, promoting and advertising of unhealthy foods to the population, especially to children;

(c) Invest in improving the nutritional content of unhealthy foods;

(d) Increase transparency of nutritional information on food products, while desisting from making false and misleading health claims;

(e) Abstain from undermining public health nutrition efforts, including through such means as funding and publicizing biased research, instituting front groups and conducting expensive and onerous litigation.

67. With a view to making accountability and remedial mechanisms available and accessible to victims of violations, the Special Rapporteur recommends that States take the following steps:

[147] UN Doc A/HRC/26/31 para 63-68.

(a) Ensure that international investment and trade agreements are entered into with full transparency and participation of affected groups by conducting open discussions before, during and after negotiation of the agreements;
(b) Encourage and promote independent monitoring of activities of the State and the food industry. Urge participation of affected people and local communities in monitoring such activities;
(c) Ensure remedies through legislation and appropriate mechanisms against States and non-State actors for failure to take steps towards their obligations under the right to health and to fulfil their international commitments on reduction of diet-related NCDs. A/HRC/26/31
68. With regard to the international obligations of States, the Special Rapporteur recommends that States take the following steps:
(a) Accord primacy to the right to health in international investment and trade agreements, and ensure that the right to health is not impaired by the provisions of these agreements or their implementation;
(b) Extend assistance and cooperation to other States, which, due to limited resources available to them, may be unable to attain required nutrition standards, leading to an increased burden of diet-related NCDs;
(c) Formulate goals and take concrete steps, jointly and individually, to reduce the burden of diet-related NCDs in a manner that also takes into account available resources of each State.