Textual recommendation

submitted November 23, 2021 by email to the
Expert Mechanism on the Right to Development on
In its deliberations on the proposed *Convention on the Right to Development*

Textual recommendation:

13(2) bis State Parties recognize that disease prevention offers many advantages in increased workforce productivity and frugal public health and social protection services. In particular, State Parties recognize the special role of food, breastmilk substitutes, tobacco, alcohol, and chemical pollutants, toxins, and Greenhouse Gas Emission emitting activities in causing ill-health which, even if partly remediated by expensive health care, in constraining workforce productivity and depleting public social protection resources. Likewise, State Parties recognize the development-enhancing potential of water management for purifying and distributing to every rightsholder water for drinking, cooking, sanitation, crop and garden irrigation, and stainable electric power generation. States recognize the egregiously unequal exposure to development-impeding harms from pollution, childhood illness, and suboptimal water management. Accordingly, State Parties pledge to use their good offices to ensure that their laws, policies, programmes, and actions by private sector actors headquartered in their jurisdictions do not frustrate the right to development by promoting unhealthy foods and or failing to furnish engineering technical assistance and infrastructure supports to optimize public water management systems, especially where high-quality health care is not universally accessible.

This recommendation is supported by CHSL's submission to the two ongoing thematic studies on international investment law & non-state actors and the duty to cooperate, attached and available online.

Respectfully submitted,

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Quantifying the Harm of Preventable Illness Caused by Marketed Products and its Impairment of the Right to Development

submitted November 14, 2021 by email to OHCHR-emrtd@un.org in relation to thematic studies undertaken by the Expert Mechanism on the Right to Development on International Investment Law & Non-State actors and the Duty to Cooperate
by the
Office of the United Nations High Commissioner for Human Rights

On behalf of the Centre for Health Science and Law (CHSL),[1] I encourage the efforts of the United Nations Human Rights Council, Her Excellency Dr. Dr. Michelle Bachelet, United Nations High Commissioner for Human Rights, and the Expert Mechanism to revive and pursue the best aspirations of the "softer law" *Declaration on the Right to Development* adopted in 1986[2] into the form of a legally meaningful and socioeconomically and equitably impactful treaty.

Quantifying global health risks

CHSL submits to the Expert Mechanism that the *Draft Convention on the Right to Development*[3] should acknowledge in its interpretive clauses, justiciable text, and general approach that, under the current approach taken by states, sellers of food, breast-milk substitutes, tobacco, alcohol,[4] and lead-containing consumer products cause the loss of approximately 500 million Disability-Adjusted Life Years (DALYS) annually.[5] These numbers do not include other risks of some industrial activities, including risks of dangerous airborne pollution created burning solid and fossil fuels (which also contribute to climate change), pesticides, asbestos, and other chemical toxins. The appended table particularizes the number of global deaths and DALYs attributable to 87 aspects of these five main risks (including extensively detailed subcategories of 34 food risks and 20 occupational health risks).

Some foods also contribute to climate change. The Intergovernmental Panel on Climate Change estimates that food systems contribute to approximately one-third of Greenhouse Gas Emissions (21%-37%).[6]

High-Income-Countries have been generally successful in building and maintaining clean water and sanitation systems (with notable failures in some indigenous communities), as well as irrigation and hydroelectric power facilities. However, their track records on regulating the advertising and promotion of food, alcohol, tobacco, harmful pesticides (not specified in the table), and lead-based consumer products are modern stories of public health failures partly mitigated by expensive health care treatment systems. As such, in a very real sense, High-Income Countries suffer from impediments to development that are masked by health care. Effective prevention measures would spare resources in Low-Income-Countries and make them available to otherwise enhance workforce productivity and family and community life.

Similarly, while the deaths due to suboptimal breastfeeding may be undercounted by the Global Burden of Disease project (or attributed to other catch-all categories such as child growth failure, stunting, and wasting), World Health Organization experts estimated that suboptimal breastfeeding causes approximately 823,000 deaths per year due to severe diarrhea and lower respiratory tract infections[7] in children under five. Considering that deaths caused in the first few years of life ruin decades of productive participation in society (and emotionally scar families), efforts to discourage the advertising and promotion of breastfeeding alone has the potential to save tens of millions of DALYs each year. The number of deaths that the WHO attributes to suboptimal breastfeeding is double the number of annual deaths it attributes to all other pathogen-contaminated foods *combined* that are consumed by people of all ages: 420,000.[8] In addition to increasing the risk of infections, suboptimal breastfeeding is also believed to raise the risks of permanent and irreversible cognitive impairment, overweight, type 2 diabetes, and, possibly, leukemia and type 1 diabetes in children, as well as closer birth spacing and increased incidence of breast and ovarian cancers in mothers.[9] For instance, invasive *Cronobacter* (a.k.a., *C. sakazakii*) infections in infants linked to powdered infant formula—including bloodstream infections and meningitis—can result in permanent neurologic disability.[10] Other infections due to *Salmonella*, *Klebsiella*, and possibly other contaminants in powdered infant formula are likely under-reported.[11]

The sway of fossil fuel companies over government environmental policies may soon provoke some of the worst public health crises in the history of humanity. Already, ambient particulate matter pollution that is largely caused by the burning fuels causes the loss of more than 118,000 DALYs annually, according to the Global Burden of Disease Database. (See the appendix.)

Quantifying the relative health risks in High- and Low-Income Countries

According to the same database, comparing the rates of Disability-Adjusted Life Years (DALYs) lost per 100,000 population between World Bank Low-Income and High-Income regions is indicative of fetters on development. While the types of dietary shortcomings and excesses differ regionally, nutrition, alcohol, and tobacco rates of losses are high in both regions. However, the rates of lost DALYs are especially high in Low-Income Countries for three risks, and especially in comparison to High-Income-Countries:

1. **Child and maternal malnutrition:** 11,507 DALYS lost per 100,000 residents in Low-Income Countries, a 29-fold higher rate than in High-Income countries;
2. **Air pollution:** 4,735 DALYs lost/100,000 population, 7-fold higher rates per population in High-Income-Countries, and
3. **Unsafe water, sanitation, and handwashing**: 3,917 DALYs lost/100,000 population, 154-fold higher than High-Income Countries.

Likewise, advancing pharmaceutical companies' intellectual property rights at the expense of the health of populations that struggle to afford medication impedes development. Unequal access to COVID-19 vaccines is a revealing illustration. The very existence of boil-water advisories in most of the developing world impugns the dedication of the global community to the rights to both health and development—especially while private soft drink companies selling nutritionally vacuous sugary drinks packaged in disposable bottles.

Rate of Loss of diability Adjusted Life-Years (DALYS) lost per 100,000 By World Bank Income Region in 2019; Global Burden of Disease database of the Institute for Health Metrics and Evaluation: http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/75e737da20521846fa41a41e17ac84a9			
per 100,000 By World Bank Income Region in 2019	High-Income Countries	Low-Income Country	Ratio of Rates (low:high income)
Child and maternal malnutrition	398	11,507	29
Environmental/occupational risks	2,109	9,307	4
Child growth failure	57	4,799	84
Air pollution	672	4,735	7
Child wasting	57	4,404	78
Unsafe water, sanitation, and handwashing	25	3,917	154
Metabolic risks	6,506	3,333	1
Unsafe sex	137	1,772	13
High systolic blood pressure	2,632	1,759	1
Child underweight	52	1,542	30
Dietary risks	2,340	1,185	1
High fasting plasma glucose	2,651	1,181	0
Tobacco	3,793	1,160	0
High body-mass index	2,712	924	0
Alcohol use	1,519	888	1
Occupational risks	881	830	1
Child stunting	0	756	1,782
Iron deficiency	71	728	10
Suboptimal breastfeeding	3	589	184
High LDL cholesterol	1,202	518	0
Non-optimal temperature	494	364	1
Vitamin A deficiency	0	268	886
Intimate partner violence	68	230	3
Other environmental risks	146	205	1
Drug use	891	134	0
Childhood sexual abuse and bullying	117	105	1
Low physical activity	300	63	0

As the forthcoming thematic studies on the roles of non-state actors and investment treaties may also soon reveal, the advertising and promotion of such products worsens health everywhere and is especially worrisome in countries where high quality health care is not widely accessible. Doing so is tantamount to inflicting death and disability on societies that are least able to mitigate risks.

Impediments to health are also impediments to development, especially where healthcare systems are underdeveloped. In an important way, High-Income Countries have succeeded by permitting health-eroding industries to flourish in step with health care systems, pharmaceutical treatments, and medical technologies that partially offset the negative impacts of such risks.

RECOMMENDATIONS

1. **Codify conflict-of-interest safeguards.** Considering the above and in light of persistent and growing concern about the industry interference in health policymaking, the *Convention on the Right to Development* should be cautious about referring to "partnerships" with nonstate actors as indicated in the call for inputs to the The Duty to Cooperate and Non-State Actors. The call for input on the thematic report on the right to development in international investment properly recognizes investors as "duty holders." However, the Expert Mechanism should be explicit about the risk that, without enforcement mechanisms, soft-law duties may yield to the enforceable legal duties that investors ow to their shareholders and that commercial spokespeople owe to employers. The hierarchy of rights created by differential enforcement possibilities poses a drafting and political challenge for convention proponents.

2. **Recognize and correct the resource imbalance between commercial and public interest civil society organizations.** Citizen and public interest groups rarely have full party standing in disputes concerning international investment treaties between member states. Private corporations sometimes do. As such, there are few opportunities for human rights advocates to initiate test-case litigation to advance human rights in international commercial matters and, for instance, shape the right to development in public international law. Human-rights experts acting as *amicus curiae* can help ensure that judges and arbitrators make better informed decisions on this point. However, they may tend to be mere witnesses to the legal limits of international human rights law in trade and investment matters. Reportedly, when national governments launch trade disputes, they often do so with financial and in-kind support from affected industries. The amounts of such funding are generally not publicly disclosed. Knowing more about these arrangements would put the funding available to finance *amicus curiae* counsel into a meaningful new light.

3. **Recognize and correct the special need for financial and technical support for fundamental water infrastructure systems.** Successful development depends on purification and distribution of piped water to households for drinking, cooking, sanitation, and irrigation, and to communities for electric power generation. Water infrastructure is expensive to build but becomes a frugal, core public service in many high-income countries. Underdeveloped water management systems make home life and work needlessly time-consuming, cause diseases that impair productivity, interfere with nutrient absorption, and often cause irreversible physical and cognitive stunting, impair crop yields, and deprive populations of renewable energy. So long as people struggle to feed their families, struggle to stay healthy, and lack energy to use labour-saving devices, their potential for personal and community development will be stymied.

Taken together, poor nutrition, tobacco, alcohol, unsafe drinking water and sanitation, air pollution, exposure to toxins, and workplace health and safety risks cause the vast majority of preventable deaths and as many a three-quarters of all lost DALYs. The contribution of these marketed products—including their restraint on workforce productivity and increasing the need to care for and provide for the surviving families of the dead and disabled—warrants attention in the proposed *Convention on the Right to Development*. Negotiators should appreciate that impediments to good health restrain development everywhere, but especially in places where access to access to high quality health care is suboptimal. Expressly asserting member states' authority to, for instance, prevent the advertising and promotion of alcohol, tobacco, food and bottled water, conflict-of-interest safeguards, and support for water management seem both warranted and essential.

Respectfully submitted,

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ENDNOTES

[1] CHSL is a non-profit organization based in Ottawa, Canada. It accepts no funding from industry beyond the trivial amount a few spend to subscribe to its consumer magazine and attends its biennial conferences. During COVID-19, it has accepted a small amount of non-discretionary funding available to support Canadian magazines.

[2] *Declaration on the Right to Development* adopted by General Assembly Resolution 41/128 of 4 December 1986. Available at: https://www.ohchr.org/en/professionalinterest/pages/righttodevelopment.aspx

[3] *Draft Convention on the Right to Development*. Human Rights Council Working Group on the Right to Development, Twenty-first session, 4–8 May 2020. Item 4 of the provisional agenda, Review of progress made in the promotion and implementation of the right to development Chair-Rapporteur: Zamir Akram (Pakistan). Available at: https://undocs.org/A/HRC/WG.2/21/2

[4] World Health Organizations. *Global Status Report on Alcohol and Health 2018*. Geneva: WHO. Available at: https://apps.who.int/iris/rest/bitstreams/1151838/retrieve

[5] Institute for Health Metrics and Evaluation. Global Burden of Disease database. (Seattle: IHME, 2019). Permanent link: http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/d9d21eca7b698e71df5100170a5c66b9 A formatted version of the table is appended to this submission. See also: Roth GA, Mensah GA, et al. on behalf of the Global Burden of Disease- National Heart, Lung, and Blood Institute and the Journal of the American College of Cardiology (JACC) Global Burden of Cardiovascular Diseases Writing Group. Global Burden of Cardiovascular Diseases and Risk Factors, 1990-2019: Update from the GBD 2019 Study. *JACC*. 2020 Dec 22;76(25):2982-3021. doi: 10.1016/j.jacc.2020.11.010. Erratum in: *JACC*. 2021 Apr 20;77(15):1958-1959. PMID: 33309175; PMCID: PMC7755038. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7755038/

[6] Intergovernmental Panel on Climate Change (IPCC). *Special Report: Special Report on Climate Change and Land, CH05, Food Security*. Executive Summary. 2019. Available at: https://www.ipcc.ch/srccl/chapter/chapter-5/

[7] Cesar G Victora, Rajiv Bahl, et al. for The Lancet Breastfeeding Series Group. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effects. *The Lancet*. Vol 387 January 30, 2016 Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01024-7/fulltext estimated that 823,000 children die from suboptimal breastfeeding. *The Lancet's* 2016 total was not disaggregated regionally, the World Health Organization did estimate regional and global totals in 2009 based on 2004 data, finding that nearly 38% of global deaths occurred in Africa. See WHO. Global Health Risks: Mortality and burden of disease attributable to selected major risks. Geneva: WHO, 2009. P. 50, table A3 "Table A3: Attributable mortality by risk factor and income group in WHO regions, estimates for 2004."
Available at: https://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

[8] Hoffmann S, Devleesschauwer B, Aspinall W, Cooke R, Corrigan T, Havelaar A, Angulo F, Gibb H, Kirk M, Lake R, Speybroeck N, Torgerson P, Hald T. Attribution of Global Foodborne Disease to Specific Foods: Findings from a WHO Structured Expert Elicitation. *Public Library of Science One.* 2017 Sept. 14;12(9):e0183641. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5598938/pdf/pone.0183641.pdf

[9] *Supra*, note 5.

[10] Jonathan Strysko, Jennifer R. Cope, et al., Author affiliations: Centers for Disease Control and Prevention, Atlanta, Georgia, USA, Food Safety and Invasive *Cronobacter* Infections during Early Infancy, 1961–2018 - Volume 26, Number 5—May 2020 - *Emerging Infectious Diseases Journal* – U.S. Center for Disease Control.

[11] WHO. HIV and infant feeding: framework for priority action. Geneva: WHO, 2003. HIV and Infant Feeding: New Evidence and Programmatic Experience (Report of the Technical Consultation, Geneva, Switzerland, 25-27 October 2006, held on behalf of the interagency task team (IATT) on preventing HIV infection in pregnant women, mothers and their infants (2007) at 2. See also, CHSL submission to the WHO Public consultation on the *Draft WHO Global Strategy for Food Safety*, June 18, 2021. Available at: http://healthscienceandlaw.ca/wp-content/uploads/2021/06/CHSL-FullSubmission.WHO-Draft-Food-Safety-Strategy.June18-2021.pdf