GLOBAL HEALTH GOVERNANCE AND THE CONTENTIOUS POLITICS OF HUMAN RIGHTS: MAINSTREAMING THE RIGHT TO HEALTH FOR PUBLIC HEALTH ADVANCEMENT

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This Article traces the political history leading up to the World Health Organization's (WHO's) invocation of human rights as a normative framework for global health governance. With both the Universal Declaration of Human Rights

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(UDHR) and WHO coming into existence in 1948, there was great initial promise that these two institutions would complement each other, with WHO—like the other specialized agencies of the United Nations (U.N.)—supporting human rights through all its activities. Yet in spite of this promise and early WHO support for advancing a human rights basis for its work, WHO intentionally neglected human rights discourse during crucial years in the development and implementation of the right to health, projecting itself as a technical organization above "legal rights."

Where WHO neglected human rights, it did so to the detriment of public health. After twenty years shunning human rights discourse, WHO's public health leadership came to see human rights principles as a moral foundation upon which to frame WHO's Health for All strategy for primary health care. But it was too late. WHO's failure to shape the evolution of international human rights law—specifically, as laid out in Table 1 below, its actions in rights development and programmatic implementation during the transition from Article 25 of the 1948 UDHR to Article 12 of the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR)—had already set into motion a course for health rights that would prove fatal to the goals of primary health care laid out in the 1978 Declaration of Alma-Ata.

Table 1 – Seminal Documents in the Evolution of the Right to Health

Universal Declaration of Human Rights (1948)	International Covenant on Economic, Social, and Cultural Rights (1966)	Declaration of Alma-Ata (1978)
Article 25 (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.	Article 12 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.	I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

This Article chronicles the evolution of a human right to health, focusing on WHO's role in developing and implementing these legal obligations. Through legal analysis of treaty language and historical analysis of treaty *travaux préparatoires* (official preparatory documents)—complemented by archival research examining the internal communications of both the U.N. and WHO—this research examines WHO's contributions to (and, in many cases, negligence of) the evolution of the right to health, analyzing how WHO has mediated the translation of health discourse into health rights. While other studies have examined the treaty language of the right to health,[1] no previous study has examined the underlying organizational discourses that developed the basis for international treaty negotiations. Only through an analysis of these institutional communications in global health governance does it become possible to understand the seminal competing norms that culminated in the international legal language of the human right to health, highlighting the institutions underlying the successes and failures of those norms in achieving state obligations for health.

I. FOUNDATION OF WHO, HUMAN RIGHTS FRAMEWORKS, AND INTERNATIONAL SYSTEMS OF COORDINATION IN PUBLIC HEALTH AND HUMAN RIGHTS

The codification of health as a human right begins, as with all contemporary human rights, in the context of World War II. Heeding a growing call for individual freedom from the tyranny of the state, U.S. President Franklin Delano Roosevelt announced to the world on January 6, 1941 that the post-War era would be founded upon four "essential human freedoms": freedom of speech, freedom of religion, freedom from fear, and freedom from want.[2] It is the final of these "Four Freedoms," freedom from want, that introduced a state obligation to provide for the health of its peoples. As Roosevelt conceived of it, this freedom from want would be couched in the language of liberty, with the understanding that "[n]ecessitous men are not freemen."[3] These budding rights, developed by the Allied States during the course of World War II,[4] would become the basis for a new system of international law, with social and economic rights serving to prevent deprivations like those that had taken place during the Great Depression and War that followed.[5] Rather than simply appealing to informal notions of religious principle or morality, these binding human rights obligations on states would provide a formal basis for assessing and adjudicating principles of justice under law.[6]

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1 *See generally* BRIGIT C.A. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW (1999).

2 FRANKLIN DELANO ROOSEVELT, THE ANNUAL MESSAGE TO CONGRESS (Jan. 6, 1941), *reprinted in* 9 THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT 663, 672 (Samuel I. Rosenman ed., Russel & Russel 1969).

3 Franklin Delano Roosevelt, President Franklin Roosevelt's 11 January 1944 Message on the State of the Union, *in* 90 CONGRESSIONAL RECORD 55, 57 (U.S. Gov't Printing Office 1944).

4 *See* U.S. DEP'T OF STATE, WASHINGTON CONVERSATIONS ON INTERNATIONAL ORGANIZATION, DUMBARTON OAKS 2297 (U.S. Gov't Printing Office 1945).

5 *See* CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL, AND CULTURAL RIGHTS (Audrey R. Chapman & Sage Russell eds., 2002).

6 JACK DONNELLY, UNIVERSAL HUMAN RIGHTS IN THEORY AND PRACTICE 20–21 (2d ed.

The Charter of the United Nations (U.N. Charter), signed on June 26, 1945, became the first major international legal document to recognize the concept of human rights. Although the U.N. Charter did not enumerate or elaborate human rights, the subject was raised as one of the four principal purposes of this nascent world body.[7] Operating through its Economic and Social Council (ECOSOC), the U.N. would seek to "make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all."[8] During the initial drafting of the U.N. Charter, however, states did not mention health, either as a goal of the organization or as a human right. In fact, original drafts do not include any mention of health.[9] But for the belated efforts of the Brazilian and Chinese delegations to the 1945 U.N. San Francisco Conference on International Organization[10]—jointly proposing the word "health" as a matter of study for the General Assembly (Art. 13), finding international health cooperation to be among the purposes of ECOSOC (Art. 55), and advocating for the establishment of an international health organization (Art. 57)[11]—health would have received no mention in the creation of the U.N.[12] Notwithstanding this promise of international health cooperation in the U.N. Charter, it fell to the subsequent human rights treaties to codify a human right to health in international law.

In doing so, the U.N. proclaimed its UDHR on December 10, 1948, enacting through it "a common standard of achievement for all peoples and all nations."[13] Defining a collective set of interrelated social welfare rights, the emerging U.N. framed a right to health in the UDHR by which:

> Everyone has the right to *a standard of living adequate for the health and well-being* of himself and of his family, including food, clothing, housing and *medical care* and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[14]

In preparing this right to a standard of living adequate for health, there was widespread agreement that a human right to health included both the fulfillment of necessary medical care and the realization of underlying determinants of health—explicitly including within it public health obligations for food and nutrition, clothing and housing, and social services.[15] This expansive vision of public health sys-

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[7] U.N. Charter preamble.

[8] *Id.* art. 62, para. 2.

[9] *Health and the Nations*, 246 LANCET 177, 177 (1945).

[10] Interview with Szeming Sze, WHO: From Small Beginnings, *in* 9 WHO FORUM 29, 29–34 (1988).

[11] U.N. Econ. & Soc. Council [ECOSOC], U.N. Doc. E/9/Rev.1. (Feb. 15, 1946).

[12] *News from the Field: Summary of Actions Related to Public Health During United Nations Conference in San Francisco*, 35 AM. J. PUB. HEALTH 1106, 1106 (1945).

[13] Universal Declaration of Human Rights, G.A. Res. 217A (III), at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 10, 1948).

[14] *Id.* art. 25(1) (emphasis added).

[15] *See* U.N., THESE RIGHTS AND FREEDOMS (1950); *Article 25*, *reprinted in* THE UNIVERSAL

tems was in accordance with (1) the expansion of post-War European welfare policy, founded on the notion that "social security" requires health to be cared for along comprehensive lines;[16] (2) the early development of human rights in the Americas, encompassing "the right to the preservation of [] health through sanitary and social measures relating to food, clothing, housing and medical care;"[17] and (3) the recent amendments to the Soviet Constitution, which established protections of medical care and "maintenance in old age and also in case of sickness or disability."[18] While the resulting language of this right was less focused than many had hoped, delegates expected that this broad declaratory language on underlying determinants of health would soon be elaborated by specific legal obligations.

With adoption of the UDHR still underway, the rapid drafting and adoption of the Constitution of the World Health Organization (WHO Constitution) would make it the first international treaty to find a unique human right to health and would form the inspirational backdrop for the development of the UDHR's human rights language on health.[19] During the June-July 1946 International Health Conference, delegates adopted the proposed WHO Constitution, thereby establishing an Interim Commission to subsume within WHO all of the prior obligations of the Health Organization of the League of Nations, the *Office International d'Hygiene Publique* (OIHP), and the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA).[20] To create this sweeping global health policy architecture, the International Health Conference established three organs by which to realize the goals of the new organization: (1) the World Health Assembly, the legislative policy-making body of WHO, made up of representatives from each member state; (2) the Executive Board, an executive program-developing subset of the World Health Assembly; and (3) the Secretariat, the body that carries out the decisions of the aforementioned organs through an elected Director-General and appointed staff of WHO. Recognizing a necessity to facilitate international cooperation through autonomous global health governance,[21] representatives of sixty-one states signed the WHO Constitution on July 22, 1946, after which it remained open for signature until it came into force on April 7, 1948. The first World Health Assembly, with fifty-four member states, met in Geneva in June 1948 to establish WHO as a specialized agency of the U.N. and to lay out WHO's mandate, programs, and priorities for realizing global public health.[22]

In establishing the contours of a human right to health under the WHO Constitution, a document far more extensive and expansive than those of its institu-

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DECLARATION OF HUMAN RIGHTS: A COMMENTARY 384, 384 (Asbjorn Eide et al. eds., 1993).

[16] *See* WILLIAM BEVERIDGE, SOCIAL INSURANCE AND ALLIED SERVICES 7–13 (1942).

[17] American Declaration of the Rights and Duties of Man, Organization for American States Res. XXX, art. XI, OEA/Ser.L/V/II.23, doc. 21 rev. 6 (1948).

[18] Konstitutsiia SSSR, art. 120 (1936), *reprinted in* USSR, SIXTY YEARS OF THE UNION 1922–1982: A COLLECTION OF LEGISLATIVE ACTS AND OTHER DOCUMENTS 229 (M. Georgadze ed., 1982).

[19] *See* ALBERT VERDOODT, NAISSANCE ET SIGNIFICATION DE LA DÉCLARATION UNIVERSELLE DES DROITS DE L'HOMME 233–41 (1964).

[20] Wilbur A. Sawyer, *Achievements of UNRRA as an International Health Organization*, 37 AM. J. PUB. HEALTH 41, 56 (1947).

[21] Szeming Sze, *Today's Global Frontiers in Public Health*, 35 AM. J. PUB. HEALTH 96, 98 (1945); Trygve Lie, Secretary-General's Message to the 2nd Session of the Interim Commission of the WHO (Nov. 6, 1946) (on file with author).

[22] Neville M. Goodman, *First World Health Assembly*, 252 LANCET 265, 265 (1948).

tional predecessors,[23] the preamble declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," defining health positively to include "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[24] To broaden the mandate of international public health far beyond the "absence of disease" originally envisioned by early International Sanitary Conventions,[25] the International Health Conference "extended [WHO] from the negative aspects of public health—vaccination and other specific means of combating infection—to positive aspects, i.e., the improvement of public health by better food, physical education, medical care, health insurance, etc."[26] In meeting this expansive vision of underlying determinants of health, commensurate with public health's contemporaneous focus on "social medicine,"[27] the preamble further declares that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[28] Under such far-reaching legal principles, the WHO Constitution created a veritable "Magna Carta of health,"[29] "represent[ing] the broadest and most liberal concept of international responsibility for health ever officially promulgated"[30] and encompassing the aspirations of the global community to build a healthy world out of the ashes of World War II.[31]

In developing and implementing these health rights across the U.N. and its specialized agencies—then numbering ten U.N. specialized agencies conducting autonomous programs in their respective fields of competence—WHO would have the benefit of a robust international system of procedures for cooperation and coordination in human rights. Cooperation in human rights was institutionalized through ECOSOC, to which the U.N. delegated authority to "make or initiate studies and reports with respect to international economic, social, cultural, educational, health, and related matters and . . . make recommendations with respect to any such matters to the General Assembly, to the Members of the United Nations, and to the specialized agencies concerned."[32] Operating through its commissions and subcommissions, the ECOSOC Commission on Human Rights—entrusted to make recommendations for the purpose of "promoting universal respect for, and obser-

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[23] *See* RUTH D. MASTERS, INTERNATIONAL ORGANIZATION IN THE FIELD OF PUBLIC HEALTH (1947); Frank Gutteridge, *The World Health Organization: Its Scope and Achievements*, 37 TEMPLE L.Q. 1, 3–4 (1963).

[24] Constitution of the World Health Organization preamble, July 22, 1946, 62 Stat. 2697, 14 U.N.T.S. 185 [hereinafter WHO Constitution].

[25] Charles C. Ascher, *Problems in the World Health Organization's Program*, 6 INT'L ORG. 27, 27 (1952).

[26] Andrija Štampar, *Suggestions Relating to the Constitution of an International Health Organization*, *in* 1 WHO OFFICIAL RECORDS ANNEX 9, 54 (1949).

[27] *See* JOHN A. RYLE, CHANGING DISCIPLINES: LECTURES ON THE HISTORY, METHOD AND MOTIVES OF SOCIAL PATHOLOGY 100 (1948); RENE SAND, L'ÉCONOMIE HUMAINE PAR LA MÉDECINE SOCIALE 14 (1934); HENRY ERNEST SIGERIST, MEDICINE AND HUMAN WELFARE (1941).

[28] WHO Constitution preamble, *supra* note 24.

[29] Thomas Parran, *Remarks at Concluding Meeting of International Health Conference*, U.N. Doc. E/H/VP/18. at 2 (1946), *reprinted in* Thomas Parran, *Chapter for World Health*, 61 PUB. HEALTH REP. 1259, 1265 (1946).

[30] Charles E. Allen, *World Health and World Politics*, 4 INT'L ORG. 27, 30 (1950).

[31] *See* Sissela Bok, *Rethinking the WHO Definition of Health* 2–5 (Harvard Ctr. for Population and Dev. Studies, Working Paper Vol. 17, No. 1, 2004).

[32] U.N. Charter art. 62(1).

vance of, human right and fundamental freedoms for all"[33]—would bear responsibility for translating the proclaimed rights of the UDHR into international treaty obligations that could be legally binding on state parties.[34] This Commission on Human Rights, drawing on the bureaucratic efforts of the U.N.'s Division of Human Rights, would coordinate states and international organizations in developing and implementing the international legal obligations necessary to realize human rights norms.

Outside of these formal human rights institutions, WHO would work cooperatively with other U.N. specialized agencies—including principally the International Labor Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), and the Food and Agriculture Organization (FAO)—to create joint policies and programs, exchanges of information, and technical meetings in implementing human rights. For specialized bodies beyond the U.N. agency system (e.g., the United Nations Children's Fund (UNICEF), International Bank for Reconstruction and Development (World Bank), and International Committee of the Red Cross (ICRC)), relationships for specific programs would develop through consultations and mutual *ad hoc* agreements. Further, state governments, intergovernmental organizations, and nongovernmental organizations would all influence international efforts to define human rights for health. National governments sent memoranda to the Division of Human Rights, Commission on Human Rights, and U.N. Secretary-General to influence draft language of various international documents, which in most cases were finalized by state delegates themselves. Intergovernmental organizations outside of the U.N. system—most prominently seen in the Council of Europe's 1950 European Convention for the Protection of Human Rights and Fundamental Freedoms and 1961 European Social Charter—worked to draft their own distinct obligations, often doing so in a way that would complement U.N. efforts.[35] Finally, nongovernmental organizations, both those officially recognized for consultations under the U.N. Charter or WHO Constitution and those simply sending organizational resolutions and memoranda to the U.N. and WHO, had their views taken into consideration in the development and implementation of human rights. While a bevy of nongovernmental organizations held official relationships with WHO, collaboration with nongovernmental organizations for the advancement of health rights centered around the World Medical Association, founded in 1946 as the first international medical organization,[36] and the Council for International Organizations of Medical Sciences (CIOMS), established in 1949 (as the Council for the Co-ordination of International Congresses of Medical Sciences) through the cooperative efforts of WHO and UNESCO.[37] With this backdrop of institutional support inside and outside of the U.N., WHO set out to develop health rights in international law and implement this law through global health policy.

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[33] ECOSOC Res. 1/5, at 123 (Feb. 16, 1946) (on file with author).

[34] U.N. Charter art. 62(2).

[35] *See* H.D.C. ROSCAM ABBING, INTERNATIONAL ORGANIZATIONS IN EUROPE AND THE RIGHT TO HEALTH CARE 77–89 (1979).

[36] T.C. Routley, *Aims and Objects of the World Medical Association*, 1 WORLD MED. ASS'N BULL. 18, 18 (1949).

[37] *See* ZENON BANKOWSKI & ROBERT J. LEVINE, ETHICS AND RESEARCH ON HUMAN SUBJECTS: INTERNATIONAL GUIDELINES (1993).

II. THE BIRTH, DEATH, AND RESURRECTION OF HUMAN RIGHTS IN WHO PROGRAMMING

This Part chronicles the political dynamics of WHO in the evolution of human rights for health, from the 1948 inception of WHO to the immediate aftermath of the 1978 Declaration of Alma-Ata. While scholars have reached contradictory conclusions on WHO's role in the development and implementation of human rights—finding either that WHO had an influential presence in the evolution of human rights discourse,[38] or that public health and human rights always "evolved along parallel but distinctly separate tracks," joined for the first time at the advent of the HIV/AIDS pandemic[39]—both of these accounts present an incomplete history of global health governance, overlooking WHO's influence on human rights codification in its early years and the consequences that resulted when WHO subsequently renounced its authoritative role as a leading voice for health rights. Despite its early leadership at the intersection of health and human rights, WHO came to reposition itself in global health governance as a purely technical organization, focusing on medical intervention and disease eradication to the detriment of rights advancement. In the midst of WHO's role in the transition from the UDHR in the ICESCR, the WHO Secretariat walked away from its efforts to formulate the international legal language of the right to health and to apply this language in its public health programming. When WHO sought to reclaim the mantle of human rights in the pursuit of its Health for All strategy, its past neglect of rights-based strategies left it without the human rights legitimacy necessary to implement primary health care pursuant to the Declaration of Alma-Ata.

A. WHO Influences Human Rights (1948-1952) – The Draft International Covenant on Human Rights

From the moment of its inauguration at the First World Health Assembly, WHO sought to pursue dual policy paths in its work: an extension of previous technical work in international health coordination—including epidemiological collection, sanitary conventions, and pharmaceutical standardization—and an ambitious rights-based project in national health promotion, both to bring the resources of science and medicine to the major problems and neglected countries of the world and to establish national public health systems to address underlying determinants of health.[40]

In the aftermath of World War II, a unique and unrepresentative moment in the history of ideas surrounding health, health technologies—in the form of new medical techniques, newly-discovered scientific therapies, and global epidemiologic surveillance systems—had created unlimited possibilities to extend and improve life. These "miracles of modern science" were dramatically showcased by the wartime success of the Health Division of UNRRA, which had acted to provide

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[38] Philip Alston, *The United Nations' Specialized Agencies and Implementation of the International Covenant on Economic, Social and Cultural Rights*, 18 COLUM. J. TRANSNAT'L L. 79, 88 (1979).

[39] Sofia Gruskin, Edward J. Mills & Daniel Tarantola, *History, Principles, and Practice of Health and Human Rights*, 370 LANCET 449, 449 (2007).

[40] *International Health or World Health?*, 252 LANCET 260, 260 (1948).

basic medical services, medical and sanitation supplies, and DDT (dichloro-diphenyl-trichloroethane) to war-ravaged nations. Reflecting on this moment, public health scholars have noted that "[t]he attitude at the time seemed to be that much was expected of new tools such as antibiotics and DDT developed during the war and that the necessary resources would be available without interruption because finally there would be no more war."[41] Through the establishment of a permanent health secretariat in WHO, "newly-discovered scientific knowledge was to make possible and also to provide the stimulus for more effective international health work,"[42] with the health functions of UNRRA and other international health organizations transferred to the Interim Commission of WHO and forming the basis of WHO's post-constitution programming. As encapsulated in the faith of WHO's first Director-General in achieving rights-based health policy, "I strongly believe that with all the marvellous [sic] tools which modern science and medicine have put at our disposal, we could make tremendous strides towards the attainment by 'all peoples of the highest possible level of health.'"[43]

Notwithstanding this moment of exultation for the observed miracles of modern medical care, leading global public health officials had long emphasized the importance of underlying determinants of health, wherein "[t]he gross relations between economic status and various indices of physical well-being has long been firmly believed in by the proponents of public health."[44] Adopting the term 'health care' rather than 'medical care' in health discourse, public health practitioners sought to acknowledge that the full development of health requires both insurance for medical services and underlying conditions for, *inter alia*, adequate nutrition, housing, education, and social security.[45] Looking to national governments to realize these interconnected economic, political, and social determinants of health, public health practitioners considered it to be "a truism" that "education and high economic status are of primary importance in the protection of health."[46] With the rise of national social welfare systems, it had become clear that health promotion, disease prevention, and rehabilitation required concerted government action through national legislation to alleviate underlying determinants of health.[47] Based upon the successes of these budding welfare states in the developed world, which were initially designed to provide comprehensively for medical care and underlying determinants of health, public health experts sought to transplant this success of the developed world to the developing world, observing that health "comes to underdeveloped areas only by patient training of public health personnel and the development of reasonably well-organized national and local public health depart-

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[41] F.H. QUIMBY, THE POLITICS OF GLOBAL HEALTH: PREPARED FOR THE SUBCOMMITTEE ON NATIONAL SECURITY POLICY AND SCIENTIFIC DEVELOPMENTS OF THE COMMITTEE ON FOREIGN AFFAIRS, U.S. HOUSE OF REPRESENTATIVES 13 (U.S. Gov't Printing Office 1971).

[42] WHO, THE FIRST TEN YEARS OF THE WORLD HEALTH ORGANIZATION 37 (1958).

[43] B.C. Chisholm, *Is the World Health Organisation Succeeding in Its Work?*, *in* UPHILL: NINE LEADING FIGURES ON UN'S PROGRESS AND DIFFICULTIES 24, 27 (Pollak ed., 1951).

[44] EDGAR SYDENSTRICKER, HEALTH AND ENVIRONMENT 85 (1933).

[45] *See* J.B. Grant, *International Trends in Health Care*, 38 AM. J. PUB. HEALTH 381, 381–82 (1948).

[46] G.H. de Paula Souza, *Today's Global Frontiers in Public Health: Discussion*, 35 AM. J. PUB. HEALTH 111, 112 (1945).

[47] *See* Grant, *supra* note 45, at 382.

ments."[48]

Given these understandings of individual medical services and underlying determinants of the public's health, the first World Health Assembly: (1) recommended that governments take preventive, curative, legislative, social, and other steps to prevent disease and promote health; (2) gave priority in WHO technical assistance to malaria, tuberculosis, venereal disease, maternal and child health, nutrition, environmental sanitation, and public health administration; and (3) delegated expansive authority to the WHO Secretariat to design and carry out policy details.[49] Transitioning from previous international emphasis on the transmission of disease, WHO would carry out its global programs to focus on stemming disease at its source, seeking to coordinate and improve the development of national health systems through the pooling of global knowledge and experience.[50] As justified by WHO's Director-General, "[a] community is more effectively protected against pestilential disease by its own public-health service than by sheltering behind a barrier of quarantine measures."[51] To develop these public health policies as part of national health systems, in accordance with the organization's explicit constitutional functions, WHO's work under its Expanded Programme of Technical Assistance for Economic Development would encompass the range of accepted public health practice:

(1) national public health administrations and national health programs,
(2) education of medical, nursing, and auxiliary staff,
(3) communicable diseases,
(4) Health Demonstration Areas,
(5) production of antibiotics and insecticides,
(6) food production and health promotion,
(7) maternal and child health,
(8) industrial health,
(9) health education, and
(10) nutrition.

It is in this undercurrent of social medicine—this understanding of the limits of technological progress, and correspondingly, the importance of national public health systems to address underlying determinants of health[52]—that WHO concerned itself with what it considered an "inseparable triad" for health policy—"the interdependence of social, economic and health problems."[53] To address these interrelated determinants of health through intersectoral policy, WHO sought to coordinate interdisciplinary approaches to public health through *ad hoc* collaborations

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48 Paul F. Russell, *International Preventive Medicine*, 71 SCI. MONTHLY 393, 399 (1950).

49 *See* J.A. Doull & M. Kramer, *The First World Health Assembly*, 63 PUB. HEALTH REP. 1379, 1379-403 (1948).

50 *See* MASTERS, *supra* note 23, at 23–30.

51 WHO Dir-Gen., *Explanatory Memorandum*, *in* 37 WHO Official Records 330 (1951).

52 *See* F.A.E. CREW, MEASUREMENTS OF THE PUBLIC HEALTH: ESSAYS ON SOCIAL MEDICINE (Oliver and Boyd 1948).

53 The WHO Director-General, *Report of the Director-General on the Work of the WHO in 1952, delivered to the World Health Assembly and the United Nations*, U.N. Doc. E/2416/Add.1.

with other agencies and organizations, often with other organizations providing funding for WHO personnel and programming.[54] Although many actors—nongovernmental, governmental, and intergovernmental—would be enlisted in the work of public health, WHO formulated the policy and coordinated the action, with the U.S. Representative to the WHO Executive Board finding at the end of this period that "under the leadership of the World Health Organization the various national and international programs have become, in a very real sense, a single, unified movement with a common goal and common methods of attaining that goal."[55] With a synoptic view of health determinants and a predilection toward interagency collaboration to attain its global health goals, the WHO Secretariat sought to work with the U.N. to apply human rights for health.

In fulfilling its health mission under human rights frameworks, WHO's early years—under the leadership of Brock Chisholm, the Executive Secretary of the Interim Commission and then first WHO Director-General—were marked by its active role in drafting human rights treaty language and its cooperative work with other U.N. agencies to expand human rights principles for public health. Complementing this rights-based discourse, WHO's efforts sought an active role for international law to prevent disease and promote health, incorporating human rights principles in global health policy (often through binding agreements and regulations[56]) and attempting to achieve the "highest attainable standard" of health through public health program efforts focusing on the benefits of scientific progress and the improvement of socioeconomic determinants of health.[57] During this time, WHO stayed apprised of the work of the Commission on Human Rights, and likewise, the U.N. Division of Human Rights sought to stay apprised of all WHO activities in global health.[58] To accomplish this mutually beneficial cooperation, the main avenue of human rights cooperation between the U.N. and WHO came in relation to transforming the rights enumerated in the UDHR into legally-enforceable covenants, first in the draft International Covenant on Human Rights and subsequently in the ICESCR. Through this dedicated cooperation in the development of health rights, the WHO Secretariat would come to see its own policy preferences reflected in the international legal language of the right to health, laying the groundwork for an expansive rights-based approach to public health.

With preliminary drafts of the International Covenant on Human Rights restricted to civil and political rights—excluding the economic, social, and cultural rights of the UDHR—WHO became involved initially in international human rights discussions on the topic of human experimentation.[59] In the aftermath of World

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[54] *Id.*; *e.g.*, S.M. Keeney, *Two Cooperative Projects of WHO and UNICEF*, 68 PUB. HEALTH REP. 606, 606–08 (1953).

[55] Henry van Zile Hyde, *The Nature of the World Health Organization*, 68 PUB. HEALTH REP. 601, 605 (1953).

[56] *See* George A. Codding, Jr., *Contributions of the World Health Organization and the International Civil Aviation Organization to the Development of International Law*, 59 AM. SOC'Y INT'L L. PROC. 147, 147–48 (1965); Krzysztof Skubiszewski, *Enactment of Law by International Organizations*, 41 BRITISH YEARBOOK INT'L L. 198, 216–18 (1965).

[57] M.C. Balfour, *Problems in Health Promotion in the Far East*, 28 MILBANK MEMORIAL FUND Q. 84, 94 (1950).

[58] Memorandum from John P. Humphrey, Dir., Div. of Human Rights, U.N., to Dagmar H. Schlesinger, Liaison, U.N. Specialized Agencies (Jan. 24, 1951).

[59] *See* ECOSOC, Comm'n on Human Rights, Compilation of the Comments of Governments on

War II, it was found that Nazi physicians had taken part in "medical experiments without the subjects' consent, upon civilians and members of the armed forces of nations then at war with the German Reich . . . in the course of which experiments the[y] committed murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts."[60] Given this widespread focus on medical experimentation following the War—particularly with the prominence of the so-called *Doctors Trial*, prosecuting those Nazi physicians who participated in genocide and medical experimentation and codifying international law for medical practice in the Nuremberg Code[61]—it was not unexpected that WHO would focus much of its human rights efforts on what was originally Article 6 of the draft International Covenant on Human Rights: "No one shall be subjected to any form of physical mutilation or medical or scientific experimentation against his will."[62] With this draft article "giv[ing] rise to many problems of a medical nature," the Commission on Human Rights specifically requested in June 1949 that WHO provide "recommendations concerning the form of the article before the Commission takes any further action," "tak[ing] into account, in considering the possible revision of the text of this article, the circumstances of physical mutilation and medical and scientific experimentation under the Fascist and Nazi regimes which prompted the inclusion of this article."[63]

Cognizant of these previous atrocities but fearful that prohibitions on medical experimentation "would hinder genuine medical progress,"[64] WHO sought the counsel of nongovernmental partners and its Executive Board before communicating its February 1950 report on the draft article to the Commission on Human Rights.[65] Despite WHO's reluctance to expand human rights to encompass medical experimentation—a losing position given the ultimate language that "no one shall be subjected without his free consent to medical or scientific experimentation"[66]—this collaborative experience shaped the WHO Secretariat's engagement with human rights, and it was clear to U.N. observers that WHO sought a cooperative role with other U.N. organs to advance human rights for global health. With continuing involvement and cooperation from its nongovernmental partners in prohibitions on human experimentation,[67] WHO soon had the opportunity to transition its participa-

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the Draft International Covenant on Human Rights and on the Proposed Additional Articles, U.N. Doc. E/CN.4/365 (Mar. 22, 1950).

60 United States v. Karl Brandt, *in* TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS (1948), *reprinted in* JAY KATZ, ALEXANDER M. CAPRON & ELEANOR S. GLASS, EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS 296, 296 (1972).

61 The Nuremberg Code, *reprinted in* GEORGE J. ANNAS & MICHAEL A. GRODIN, THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION, inside cover (1992).

62 George J. Annas & Michael A. Grodin, *Medical Ethics and Human Rights: Legacies of Nuremberg*, 3 HOFSTRA L. & POL'Y SYMP. 111, 115 (1999); *see* M. Cherif Bassiouni, Thomas G. Baffes & John T. Evrard, *An Appraisal of Human Experimentation in International Law and Practice: The Need for International Regulation of Human Experimentation*, 72 J. CRIM. L. & CRIMINOLOGY 1597 (1981).

63 Letter from Henri Laugier, Assistant Sec'y-Gen., U.N., to Brock Chisholm, Dir.-Gen., WHO (Jun. 1, 1949) (on file with author).

64 ROSCAM ABBING, *supra* note 35, at 131.

65 Letter from Brock Chisholm, Dir.-Gen., WHO, to Alva Myrdal, Acting Assistant Sec'y-Gen., U.N. (Feb. 1, 1950) (on file with author).

66 International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), art. 7, U.N. Doc. A/6316 (1966).

67 Letter from Brock Chisholm, Dir.-Gen., WHO, to Trygve Lie, Sec'y-Gen., U.N. (Oct. 17,

tion to the consideration of positive human rights obligations for health. Providing these additional opportunities for WHO participation in the human rights project, the U.N. General Assembly resolved in December 1950 to expand ECOSOC human rights deliberations to include economic, social, and cultural rights in the Draft International Covenant on Human Rights,[68] seeking through the Commission on Human Rights "to obtain the cooperation" of specialized agencies in drafting articles within their respective purview.[69]

The Commission on Human Rights took up legal obligations concerning economic, social, and cultural rights in its 1951 session, giving the WHO Secretariat its first opportunity to influence the development of a human right to health. In preparation for this debate, the Commission on Human Rights requested that the U.N. Secretary-General submit a report to ECOSOC on the legal aspects of previous actions by the U.N. and its specialized agencies in relation to economic, social, and cultural rights, focusing specifically on Articles 22 through 27 of the UDHR.[70] As the U.N. reached out to WHO on these cooperative opportunities with the Commission on Human Rights,[71] WHO Director-General Chisholm responded enthusiastically in January 1951, quoting from the preambular language of the WHO Constitution and "welcom[ing] opportunities to co-operate with the Commission on Human Rights in drafting international conventions, recommendations and standards with a view to ensuring the enjoyment of the right to health."[72] To this cooperative end, Director-General Chisholm concluded his reflections:

> It is clear that the whole programme approved by the World Health Assembly represents a concerted effort on the part of the Member States to ensure the right to health. In this respect, the work they accomplish through WHO complements that which they have undertaken through the Commission on Human Rights. I am well aware of the obligation of WHO to be guided by this fundamental relationship in planning its work with governments as well as with other international organizations.[73]

With specialized agencies responding favorably to the U.N.'s request for cooperation,[74] WHO responded accordingly, following up on the Director-General's response in February 1951 with a wide range of suggestions well beyond the confines of medicine and across the range of economic, social, and cultural rights—on topics ranging from occupational health to nutrition, child welfare and maternal and child health clinics, medical and nursing education and research, and international

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1951) (on file with author).

[68] G.A. Res. 421 (V), ¶ 7, U.N. Doc. A/RES/421 (V) (Dec. 4, 1950).

[69] *See* ECOSOC Res. 349 (XII), U.N. Doc. E/RES/349 (XII) (Feb. 23, 1951).

[70] Memorandum from A.H. Feller, Acting Assistant Sec'y-Gen., Legal Dep't, U.N., to Alva Myrdal, Acting Assistant Sec'y-Gen., U.N. (May 23, 1950) (on file with author).

[71] Letter from Henri Laugier, Assistant Sec'y-Gen., U.N., to Brock Chisholm, Dir.-Gen., WHO (Jan. 3, 1951) (on file with author).

[72] Letter from Brock Chisholm, Dir.-Gen., WHO, to Henri Laugier, Assistant Sec'y-Gen., U.N. (Jan. 12, 1951) (on file with author).

[73] *Id.*

[74] *See* Alston, *supra* note 38, at 82–92.

health policy—noting related WHO collaborative activities with ILO, FAO, UNICEF, and UNESCO.[75] From this response, the Commission on Human Rights revised its survey of the activities of specialized agencies with regard to, among other articles, Article 25's declaration of rights to adequate food, clothing, housing, medical care, and social security.[76]

Expanding upon this undertaking with regard to the right to health, Director-General Chisholm reiterated in a March 1951 letter to the U.N. Secretary-General that WHO "will advice [sic] the Commission on technical matters relating to health which may arise in the course of the Commission's work and will cooperate with the United Nations, as appropriate, in assistance to governments."[77] (That same day, the WHO Assistant Director-General wrote correspondingly to the U.N. Assistant Secretary-General, going beyond technical matters and noting that WHO would continue to review its human rights activities at its upcoming Executive Board meeting.[78]) To further this cooperation with the Commission on Human Rights, arrangements were made for the WHO Secretariat to send to the Commission's June 1951 meeting the WHO Assistant Director-General, Director of the Division of Organization of Public Health Services, Director of the Division of Coordination of Planning, and Liaison to the U.N. Discouraged by WHO's expansive foray into human rights policy, Henry van Zile Hyde, the U.S. Representative to the WHO Executive Board, wrote to the Director-General, expressing his skepticism toward the successful implementation of economic and social rights and his "hope":

> that the members of the secretariat who participate in the discussion with the Commission will bear in mind the fact that guaranteeing economic and social rights in an enforceable covenant is considerably different from a declaration of objectives. Economic and social rights fall into a different category from political rights. If a nation agrees to guarantee civil and political rights, it can carry out these guaranties by passing appropriate legislation. On the other hand, in order to secure economic and social rights there must be available, over and above the willingness of the government, an adequate number of trained personnel, facilities, equipment and financial and national resources. No matter how great the desire of governments to provide such rights, some are not, unfortunately, in a position to guarantee them now. I hope that the WHO will call the attention of the Commission to these problems as well as to the problems inherent in attempting to draft en-

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[75] Letter from William P. Forrest, Div. of Coordination of Planning and Liaison, WHO, to Henri Laugier, Assistant Sec'y-Gen., U.N. (Feb. 13, 1951) (on file with author).

[76] The Secretary-General, *Survey of the Activities of Bodies of the United Nations Other than the Commission on Human Rights, and of the Specialized Agencies, in Matters within the Scope of Articles 22–27 of the Universal Declaration of Human Rights*, ¶¶ 121–31, *delivered to the Commission on Human Rights*, U.N. Doc. E/CN.4/364 (Mar. 17, 1951).

[77] Letter from Brock Chisholm, Dir.-Gen., WHO, to Trygve Lie, Sec'y-Gen., U.N. (Mar. 7, 1951) (*available at* U.N. Doc. E/1880/Add3) (on file with author).

[78] Letter from P. Dorolle, Assistant Dir.-Gen., WHO, to Henri Laugier, Assistant Sec'y-Gen., U.N. (Mar. 7, 1951) (on file with author); Memorandum from John P. Humphrey, Dir, Div. of Human Rights, U.N., to Egon Schwelb, Assistant Dir., Div. of Human Rights, U.N. (July 11, 1951) (on file with author).

> forceable rights for health services.[79]

With Director-General Chisholm thereafter adding himself as a WHO representative for the working group of the Commission on Human Rights in April 1951, WHO submitted suggested language, in implicit contradistinction to the U.S. position, noting that:

> [w]hen the question arose of including economic, social and cultural rights in the Covenant on Human Rights, the Director-General of the World Health Organization felt it was imperative that the enjoyment of the highest obtainable standard of health should be included among the fundamental rights of every human being, and desirable for provision to be made for an undertaking by Governments that adequate health and social measures should be taken to that end, with due allowance for their resources, their traditions and for local conditions.[80]

In deference to the position of the United States, however, the WHO suggestion proposed health rights obligations on a continuum, by which "[s]ome Governments with immense financial resources can concentrate on highly specialized problems and provide measures which only benefit a very small number of people, while others have still to create a medical profession and health services before they can contemplate action of any kind."[81]

Based upon these foundational norms, WHO suggested in April 1951 that the right to health should be couched in terms—drawn from the WHO Constitution and language abandoned in compromises on the UDHR[82]—that emphasize: (1) a positive definition of health; (2) the importance of social measures as underlying determinants of health; (3) governmental responsibility for health provision, and; (4) the role of health ministries in creating systems for the public's health:

- Every human being shall have the right to the enjoyment of the highest standard of health obtainable, health being defined as a state of complete physical, mental and social well-being.
- Governments, having a responsibility for the health of their peoples, undertake to fulfill that responsibility by providing adequate health and social measures.
- Every Party to the present Covenant shall therefore, so far as it [sic] means allow and with due allowance for its traditions and for local conditions, provide measures to promote and protect the health of its nationals, and in particular:

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[79] Letter from Henry van Zile Hyde, U.S. Representative to Executive Bd., WHO, to Brock Chisholm, Dir.-Gen., WHO (Mar. 28, 1951) (on file with author).

[80] WHO Director-General, *Draft International Covenant on Human Rights and Measures of Implementation*, *submitted to the Commission on Human Rights*. U.N. Doc. E/CN.4/544 (Apr. 18, 1951) (on file with author) [hereinafter WHO *Draft International Covenant*].

[81] *Id.*

[82] *See* Richard Pierre Claude & Bernardo W. Issel, *Health, Medicine and Science in the Universal Declaration of Human Rights*, 3 HEALTH & HUM. RTS. 126, 136–38 (1998).

- to reduce infant mortality and provide for healthy development of the child;
- to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
- to control epidemic, endemic and other diseases;
- to improve standards of medical teaching and training in the health, medical and related professions;
- to enlighten public opinion on problems of health;
- to foster activities in the field of mental health, especially those affecting the harmony of human relations.[83]

The Commission on Human Rights met in June 1951 to review the legal provisions concerning—among other economic, social, and cultural rights—the right to health.[84] WHO Director-General Chisholm opened discussion on the right to health by pressing for delegates to define health in the International Covenant on Human Rights, advocating adoption of the definition of complete health from the WHO Constitution. Given its widespread support among states parties to WHO, the Director-General advanced this definition based upon the widespread public health consensus that health consists not only of a "negative conception of health as representing simply freedom from disease."[85] In the wake of this impassioned plea for a right to underlying determinants of health promotion, delegates turned to negotiations over the precise language of this right, with the major amendments summarized in the Table 2[86] below:

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[83] *See* WHO *Draft International Covenant*, *supra* note 80.

[84] ECOSOC, Comm'n on Human Rights, Summary Record of the Two Hundred and Twenty-Third Meeting, 8–12, U.N. Doc. E/CN.4/SR.223 (June 13, 1951) (citing U.N. Doc. E/CN.4/582, U.N. Doc. E/CN.4/583, and U.N. Doc. E/CN.4/589).

[85] *Id.* at 8–9.

[86] *See* WHO *Draft International Covenant*, *supra* note 80 (containing the WHO proposal); ECOSOC, Comm'n on Human Rights, Report of the Seventh Session, ¶ 45, U.N. Doc. E/CN.4/1992. (containing the ECOSOC proposal); ECOSOC, Comm'n on Human Rights, Compilation of Proposals Relating to Economic, Social and Cultural Rights, at 1, U.N. Doc. E/CN.4/AC.14/2/Add.4 (April 27, 1951) (containing proposals of the United States, World Health Organization, Denmark and Egypt); ECOSOC, Comm'n on Human Rights, Summary Record of the Two Hundred and Twenty-Third Meeting, at 8–20, U.N. Doc. E/CN.4/SR.223 (June 13, 1951) (citing U.N. Doc. E/CN.4/582, U.N. Doc. E/CN.4/583, and U.N. Doc. E/CN.4/589) (containing proposals of the United Kingdom and Chile); ECOSOC, Comm'n on Human Rights, Draft International Measures on Human Rights and Measures of Implementation, at 1, U.N. Doc. E/CN.4/588 (May 2, 1951) (containing the original United Kingdom oroposal); ECOSOC, Comm'n on Human Rights, Draft International Measures on Human Rights and Measures of Implementation, at 1, U.N. Doc. E/CN.4/583 (May 1, 1951) (containing the U.S.S.R. proposal).

Table 2 – Commission on Human Rights 1951 Negotiations on a Human Right to Health

WHO Proposal (Apr. 18, 1951)	**Egypt Proposal (May 2, 1951) / Chile Proposal (May 2, 1951)** ([ ] indicates deletion in Chile Proposal)	**Denmark Proposal (Apr. 15, 1951)**	**U.S.S.R. Amendment (May 1, 1951)**	**United Kingdom Amendment (May 2, 1951)**	**ECOSOC Submission**
Every human being shall have the right to the enjoyment of the highest standard of health obtainable, health being defined as a state of complete physical, mental, and social well-being. Governments, having a responsibility for the health of their peoples, undertake to fulfill that responsibility by providing adequate health and social measures. Every Party to the present Covenant shall therefore, so far as it [sic] means allow and with due allowance for its traditions and for local conditions, provide measures to promote and protect the health of its nationals, and in particular: - to reduce infant mortality and provide for healthy development of the child; - to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene; - to control epidemic, endemic and other diseases. - to improve standards of medical teaching and training in the health, medical and related professions - to enlighten public opinion on problems of health; - to foster activities in the field of mental health, especially those affecting the harmony of human relations.	Everyone shall have the right to the enjoyment of the highest standard of health obtainable. With a view to implementing and safeguarding this right: Each State party hereto undertakes to provide legislative measures to promote and protect [the] health [of its nationals,] and in particular: 1. to reduce infant mortality and provide for healthy development of the child; 2. to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene; 3. to control epidemic, endemic and other diseases. 4. [to improve standards of medical teaching and training in the health, medical and related professions; 5. [to enlighten public opinion on problems of health; 6. [to foster activities in the field of mental health, especially those affecting the harmony of human relations.]	Each State party hereto undertakes to combat disease and promote conditions which will assure the right of all its nationals to medical care in the event of sickness.	Each State party hereto undertakes to combat disease and provide conditions which would assure the right of all its nationals to a medical service and medical attention in the event of sickness. **United States Amendment (May 2, 1951)** The States Parties [sic]to the Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable.	*Original:* Each State party hereto undertakes by combating disease and promoting favourable conditions, including the provision of medical care, to assure to all persons within its territory, as far as possible, the right to an adequate standard of health. *Revised to accommodate WHO preferences:* Each State party hereto undertakes, by combating disease, by providing legislative measures to promote and protect health and by providing favourable conditions for medical care, to assure to all persons within its territory, as far as possible, the right to an adequate standard of health.	The States parties to this Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable. With a view to implementing and safeguarding this right, each State party hereto undertakes to provide legislative measures to promote and protect health and in particular: 1. to reduce infant mortality and to provide for healthy development of the child; 2. to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene; 3. to control epidemic, endemic and other diseases; 4. to provide conditions which would assure the right of all its nationals to a medical service and medical attention in the event of sickness.

With Danish and British delegates abandoning their efforts to elevate socialized medicine to the status of a human right, the Commission on Human Rights was challenged by dueling U.S. and Soviet amendments to the working draft of the WHO proposal. As a compromise to these conflicting proposals by the post-War superpowers, the U.S. proposal—originally intended to replace the entire article—was approved only as a replacement for the opening paragraph; and likewise, with the Soviet Union critiquing the U.S. proposal for failing to define obligations on governments, its comprehensive amendment on medical care was included only as a replacement for the deleted paragraphs 4, 5, and 6.[87]

By a final vote of 10–0 (8 abstentions)—the abstentions arising largely out of the provision for medical care, the only obligation not proposed by WHO—the Commission on Human Rights concluded on June 2, 1951 with the following working draft for Article 25 of the draft International Covenant on Human Rights:

> The States parties to this Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable. With a view to implementing and safeguarding this right, each State party hereto undertakes to provide legislative measures to promote and protect health and in particular:
>
> (1) to reduce infant mortality and to provide for healthy development of the child;
>
> (2) to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
>
> (3) to control epidemic, endemic and other diseases;
>
> (4) to provide conditions which would assure the right of all its nationals to a medical service and medical attention in the event of sickness.[88]

Rather than accepting the expansive vision of "complete" health from the WHO Constitution, delegates had reverted to the delimited "highest standard of health obtainable." This limitation notwithstanding, the revised draft of the right to health—the most detailed of the economic, social, and cultural rights—placed obligations on the state to progressively realize underlying conditions for health through public health systems, reflecting in legal rights the emphasis of WHO discourse on underlying determinants of health.

On June 7, 1951, the WHO Executive Board met to review WHO's cooperation with the Commission on Human Rights, specifically discussing the role that the WHO Secretariat would play in drafting the language of what would become a human right to health. With only five days remaining before this WHO meeting, Director-General Chisholm immediately forwarded the June 2nd resolution of the Commission on Human Rights to Executive Board members, observing for his medical audience that "a distinction is made between the concept of human rights, which is an abstraction, and the concrete actions or conditions which give reality to

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[87] *Id.* at 11–12

[88] ECOSOC, Comm'n on Human Rights, Report of the Seventh Session, ¶ 45, U.N. Doc. E/CN.4/1992.

that concept" while highlighting the ways in which WHO could have a preeminent role in implementing these concrete actions.[89] In justifying the formal role that WHO would be asked to take in implementing the right to health, the Director-General found that "the provisions of the Covenant on Human Rights can and should be implemented through . . . specialized agencies and the Agreements between the U.N. and the specialized agencies," admonishing the Executive Board not to disempower WHO by allowing non-technical U.N. organs to pass judgment over health issues.[90] While the Director-General expressed concerns about lingering weaknesses in the right to health—including duplications of the provisions of other articles (e.g., right to housing, rights of children), ambiguity in WHO's relationship with other specialized agencies, and a lack of completeness resulting from the deletion of WHO's final three measures of implementation—he advocated strong WHO authority for developing, interpreting, and supervising the right to health's domestic and international obligations.[91]

In the Executive Board debate that ensued on "Co-operation with the Commission on Human Rights," the Executive Board accepted without discussion a resolution supporting the Director-General's position on provisions of implementation through the WHO, focusing its discussion on the substance of the right itself. Through its ninety-minute debate—with a member of the U.N. Human Rights Division present in an advisory role—delegates proposed changes to the language of the right to health as outlined in Table 3[92] below.

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[89] WHO, Executive Bd., 8th Sess., *Co-operation with the United Nations Commission on Human Rights*, at 13, U.N. Doc. EB8/39 (June 2, 1951).

[90] *Id.* at 14.

[91] *Id.* at 15–16.

[92] *See id.*

Table 3 – WHO Executive Board 1951 Negotiations on a Human Right to Health

EB Member (nationality)	**Proposal** (Each delegates original proposal is in the first bullet point. Compromise proposals are in subsequent bullet points. The reasoning behind each proposal is summarized in parenthetical statements.)
van Zile Hyde (U.S.)	• Delete entire second sentence of article 25 *(believing legislative measures to be the least important emphasis of public health and arguing that other articles (22, 23, 24) are limited to general statements of principle and clarified only in the umbrella clause of article 19)* • If second sentence is included, the word "any" should be deleted
Bravo (Chile)	• Second sentence of article 25 should be amended to read: "to take legislative and other measures to promote . . . ." • In the alternative, insert "if necessary" after "legislative measures"
Karunaratne (U.K.)	• Insert "any" before "legislative measures" and "necessary" before "promote and protect health. . ."
Daengsvang (Thailand)	• Delete second sentence of article 25, beginning "with a view" *(finding that (1) article 19 covered action for implementing health rights in relation to subparagraphs (i), (ii), (iii) and (iv) and (2) the current draft implies that health principles could only be implemented by "legislative measures")*
Canaperia (Italy)	• Simply omit the word "legislative" in second sentence *(arguing that "take all necessary measures" would cover all points of view)*
Padua (Philippines)	• Amend to read "to provide all necessary measures, including legislative measures . . . ." *(thereby implying that legislation was a subordinate factor)*
Jafar (Pakistan)	• Retain second sentence *(believing that legislative measures commit states parties to definite course of action)*
Hurtado (Cuba)	• Second sentence of article 25 should be amended to read: "to take legislative and all other measures to promote . . . ." *(agreeing with Bravo and arguing that it was not the task of the EB to redraft the article)*
Forrest (WHO Secretariat)	• Second sentence of article 25 should be amended to read: "to take legislative and other measures to promote . . . ."

Much of the debate centered on various proposals by U.S. member van Zile Hyde, the same representative who had earlier that year cautioned against the Director-General's approach to the right to health. With rejection of both the radical proposal by van Zile Hyde (*delete the whole of the second sentence*, 9-1 (5 abstentions)) and the prioritizing proposal by Padua (*substitute "legislative measures"*

with "all necessary measures including legislative measures," 5-3 (6 abstentions)), the Director-General—echoing debates that had taken place within ECOSOC—offered a series of compromise proposals to replace "legislative measures," being rejected in his proposal for "all administrative, technical and legislative measures" before finding acceptance (6-1 (8 abstentions)) for "legislative and other measures."[93] The Director-General would accommodate this Executive Board consensus by reporting it in a Commission on Human Rights survey of activities of specialized agencies in economic, social, and cultural rights[94] and presenting it to ECOSOC during its July-August 1951 review of the revised draft Covenant.[95] While a human right to health continued to lack the support of nongovernmental medical associations—prominently the World Medical Association, which argued that "the Constitution of the World Health Organization is broad enough to cover the subject and there seems no point to including the subject in still another covenant of the United Nations"[96]—the WHO Secretariat remained engaged in constructive U.N. debate as it took the initiative to develop the language of this right and to act upon that language in public health policy.

WHO's leadership in health rights proved influential, as the U.N. Division of Human Rights drew upon both the WHO Director-General's background document and the Executive Board meeting minutes in subsequent drafts of the Covenant.[97] When the U.N. Secretary-General published the results of the U.N.'s two-year effort to catalogue "Activities of the United Nations and of the Specialized Agencies in the Field of Economic, Social and Cultural Rights," he (1) reiterated the language of the right to health from the WHO Constitution (including WHO's definition of health as "a state of complete physical, mental and social well-being"); (2) noted WHO's interagency activities related to various underlying determinants of health, and; (3) recognized WHO for its health policies and programs related to, among other things:

> [D]rawing up Health Regulations to replace the International Sanitary Conventions; . . . providing world wide epidemiological intelligence services, setting standards for therapeutic substances, publishing the International Pharmacopoeia, and conducting research . . . ;[and] assisting its member States to raise standards of health within their countries by means of field demonstrations, advisory visits by officials of the Organization and other advisory services, the provision of literature on medical subjects and of teaching equipment, the granting of fellowships, study by expert committees and by individual research workers

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[93] Memorandum from Margaret Kitchen to John P. Humphrey, Dir., Div. of Human Rights, U.N. (June 9, 1951) (on file with author).

[94] *See* The Secretary-General, *Activities of the United Nations and the Specialized Agencies in the Field of Economic, Social and Cultural Rights, delivered to the Commission on Human Rights,* U.N. Doc. E/CN.4/364/Rev.1 (Jan. 1952).

[95] Letter from William P. Forrest, Dir., Div. of Co-ordination of Planning & Liaison, WHO, to Martin Hill, Dir. of Co-ordination for Specialized Agencies & Econ. & Soc. Matters, U.N. (June 26, 1951) (on file with author).

[96] Letter from Louis H. Bauer, Sec'y-Gen., World Med. Ass'n, to Trygve Lie, Sec'y-Gen., U.N. (Oct. 9, 1951) (on file with author).

[97] *E.g.*, Memorandum from G. Brand, Div. of Human Rights, U.N., to Egon Schwelb, Assistant Dir., Div. of Human Rights, U.N. (June 9, 1951) (on file with author).

> either in the field or at headquarters, and emergency material aid in epidemics.[98]

As the U.N. moved to develop the ICESCR, WHO would soon have a focused opportunity to advance a more comprehensive right to health.

In early 1952, the Third Committee of the United Nations—for reasons grounded in the politics of the Cold War, longstanding concerns about the universality of human rights, and Western State objections to the advisability of economic rights[99]—resolved that in place of the unified International Covenant on Human Rights, the Commission on Human Rights would draft two separate human rights covenants: one on civil and political rights and the other on economic, social, and cultural rights. In clarifying the details of this bifurcated human rights agenda, the General Assembly requested in February 1952 that ECOSOC:

> [A]sk the Commission on Human Rights to draft two covenants on human rights, to be submitted simultaneously for the consideration of the General Assembly[,] . . . one to contain civil and political rights, and the other to contain economic, social and cultural rights, in order that the General Assembly may approve the two covenants simultaneously and open them at the same time for signature . . . .[100]

By the same resolution, the General Assembly again called upon ECOSOC "to ask Member States and appropriate specialized agencies to submit drafts or memoranda containing their views on the form and contents of the proposed covenant on economic, social and cultural rights . . . for the information and guidance of the Commission on Human Rights at its forthcoming session."[101]

In accordance with this and in preparation for the April 1952 meeting of the Commission on Human Rights, the WHO Executive Board met in February 1952 to note the actions taken by the U.N. General Assembly and ECOSOC.[102] As part of this meeting, Director-General Chisholm sought approval from the Executive Board to propose again to the Commission on Human Rights that this new covenant refer to the positive definition of health contained in the WHO Constitution and that the right to health be amended to acknowledge measures taken by states to address underlying determinants of health, including:

> Endemic and epidemic diseases and their eradication or control; impairment of health by environmental conditions, deprivation and ignorance, and the understanding and acceptance of the practices which can prevent this impairment; physical, mental and social handicaps, and

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[98] The Secretary-General, *Activities of the United Nations and the Specialized Agencies in the Field of Economic, Social and Cultural Rights*, *supra* note 94, ¶ 132.

[99] Letter from John P. Humphrey, Dir., Div. of Human Rights, U.N., to Lin Mousheng, Div. of Human Rights, U.N. (Jan. 3, 1952) (on file with author).

[100] G.A. Res. 543 (VI), ¶ 5, U.N. Doc. A/RES/543 (VI) (Feb. 5, 1952).

[101] *Id.*

[102] Draft International Covenant on Human Rights, WHO, Executive Bd. Res. 102, U.N. Doc. EB9/R/102 (Feb. 4, 1952).

> their correction or mitigation by suitable care.[103]

However, because the U.N. General Assembly was still finalizing its resolution to draft two separate covenants (which it adopted the following day),[104] the WHO Executive Board postponed discussion on the Director-General's proposal,[105] focusing instead on state procedures for periodic reporting to WHO on human rights, national health legislation, and other health-related issues.[106] With vibrant discussion on rights-based reporting procedures by the WHO Secretariat, U.N. observers found that "it may be certainly deduced that the WHO will have much to say in due course concerning the problem of implementation of social rights as they touch health questions under any Covenant of Human Rights."[107]

Returning debate to the U.N., the subsequent April-June 1952 session of the Commission on Human Rights sought to clarify the language of the right to health in what was now the draft Covenant on Economic, Social, and Cultural Rights.[108] Although neither ECOSOC nor the General Assembly had discussed the right to health since the Commission's last session, the Council of Europe had made reference to lessons to be drawn from the 1950 European Convention on the U.N.'s draft Covenant on Civil and Political Rights,[109] and member states had elicited similar lessons from national legislation on the form and content of the draft Covenant on Economic, Social, and Cultural Rights.[110] To assist the Commission on Human Rights in its continued drafting, the U.N. Division of Human Rights prepared a memorandum summarizing observations from governments, specialized agencies, and representatives, which included the following WHO observation on the right to health:

> Consideration may be given to the question whether administrative measures as well as legislative measures should be mentioned in article 25 as being necessary to promote and protect health.[111]

When the Commission on Human Rights reached the right to health on May 15, 1952—now incorporated into article 13 of the draft International Covenant on Economic, Social, and Cultural Rights—state delegates presented and adopted the fol-

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[103] WHO, Executive Bd., 9th Sess., U.N. Doc. EB9/R/102 (Jan. 29 1952).

[104] Memorandum from Egon Schwelb, Deputy Dir., Div. of Human Rights, U.N., to Lin Mousheng, Dir., Div. of Human Rights, U.N. (Feb. 4, 1952) (on file with author).

[105] *Report of the United Nations Delegation at the 9th Session of the Executive Board of the World Health Organization*, 6, U.N. Doc. SG/SA/54 (Mar. 7, 1952) (on file with author).

[106] Letter from P. Dorolle, Assistant Dir.-Gen., WHO, to Guillaume Georges-Picot, Assistant Sec'y-Gen., U.N. (Feb. 27, 1952) (on file with author).

[107] *Report of the United Nations Delegation at the 9th Session of the Executive Board of the World Health Organization*, *supra* note 105, at 6.

[108] *See* ECOSOC, Comm'n on Human Rights, *Draft International Covenant on Human Rights and Measures of Implementation*, U.N. Doc. E/CN.4/666/Add.9 (May 16, 1952).

[109] Letter from A.H. Robertson, Secretariat-Gen., Council of Eur., to John P. Humphrey, Dir., Div. of Human Rights, U.N. (Jan. 24, 1952) (on file with author).

[110] *E.g.*, Letter from the U.K. Delegation to the U.N., to Trygve Lie, Sec'y-Gen., U.N., U.N. Doc. 95/1732/18/52E (Mar. 15, 1952) (on file with author).

[111] *See* ECOSOC, Comm'n on Human Rights, *Draft International Covenant on Human Rights and Measures of Implementation*, *supra* note 108.

lowing amendments in conformity with WHO's original position:

- Uruguay—expand the first sentence to include the definition of health from the WHO Constitution– "realizing that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."
- United States—contract the second sentence (over the objections of the Soviet Union and Poland) to remove the obligation of "legislative measures" in light of its general coverage under the umbrella "principle of progressive realization" clause, and specifically:
  - Replace "With a view to implementing and safeguarding this right each State Party hereto undertakes to provide legislative measures to promote and protect health and, in particular . . . ."
  - With "The steps to be taken by the States Parties to the Covenant to achieve the full realization of this right shall include those necessary for . . . ."[112]

As a result of these amendments—both in line with WHO's policy preferences—along with correcting a translation error to replace "obtainable" with "attainable standard of health," the draft text of the article on the right to health was revised to read:

> The States Parties to the Covenant, realizing that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, recognize the right of everyone to the enjoyment of the highest attainable standard of health.
> The steps to be taken by the States Parties to the Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The reduction of infant mortality and the provision for healthy development of the child;
> (b) The improvement of nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
> (c) The prevention, treatment and control of epidemic, endemic and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[113]

With the Commission on Human Rights unable to complete its drafting of the two covenants, however, ECOSOC authorized the Commission to revisit the covenants

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[112] ECOSOC, Comm'n on Human Rights, *Draft International Covenants on Human Rights and Measures of Implementation,* U.N. Doc. E/CN.4/L.79/rev.1 (May 2, 1952).

[113] ECOSOC, Comm'n on Human Rights, *Draft International Covenants on Human Rights and Measures of Implementation of the Draft Covenant on Economic, Social and Cultural Rights: Text Adopted by the Commission at Its 296th Meeting on May 15, 1952*, U.N. Doc. E/CN.4/666/Add.9 (May 16, 1952).

at its 1953 session.[114] Although WHO would continue to update the U.N. on its human rights reporting procedures into the latter half of 1952,[115] a 1953 change in leadership within the WHO Secretariat would restructure the organization's health priorities and lead it to rethink its commitment to the human rights enterprise.

B. WHO Neglects Human Rights (1953-1973) – The International Treaty Framework Expands Without WHO

As the U.N. sought to expand the right to health in the ICESCR and then extend that promise of health outward to specific groups and rights, WHO remained on the sidelines. Despite an understanding from the U.N. General Assembly that specialized agencies would take responsibility for creating detailed definitions of the human rights principles within their respective fields of action,[116] WHO took no specific actions to explain these broadly defined rights for health promotion.

Turning its attention to purely technical enterprises, which it approached through a purely medical lens, WHO pursued a vertical, disease-specific approach to international public health.[117] This technical agenda—under the leadership of Director-General Marcolino Gomes Candau, the former Director of the Division of Organization of Public Health Services—largely focused (1) at the international level on communicable disease eradication, including most prominently the prevention and control of malaria, tuberculosis, plague, cholera, yellow fever, and smallpox, and (2) at the domestic level on assisting countries through medical training and specific requests for technical assistance. As explained by WHO's chief legal officer, "a programme based on the notion of priorities has given way to one based on the needs of the countries themselves, expressed through their requests for advice and assistance."[118] Thus, despite operating with more than triple its original staff and more than double its original funding,[119] WHO abandoned its previous emphasis on global health priorities for the disadvantaged (which included non-communicable diseases and underlying determinants of health), delegating country-based technical assistance programs to its regional health offices,[120] abandoning collaborative intersectoral health work with other U.N. specialized agencies,[121] and decentralizing leadership for global health within the U.N. system.[122]

In this context, discourse on health veered away from the social medicine

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[114] ECOSOC Res. 440 (XIV), ¶ 97, U.N. Doc. E/2256 (July 30, 1952).

[115] *See* Letter from Brock Chisholm, Dir.-Gen., WHO, to Guillaume Georges-Picot, Assistant Sec'y-Gen., U.N. (Dec. 5, 1952) (on file with author).

[116] *See* Klaus T. Samson, *Human Rights Co-ordination Within the U.N. System*, *in* THE UNITED NATIONS AND HUMAN RIGHTS: A CRITICAL APPRAISAL 620 (Philip Alston ed., 1992).

[117] *See* COLIN FRASER BROCKINGTON, WORLD HEALTH (1958).

[118] Gutteridge, *supra* note 23, at 8.

[119] FRANCIS W. HOOLE, POLITICS AND BUDGETING IN THE WORLD HEALTH ORGANIZATION 33–62 (1976).

[120] *See* ROBERT BERKOV, THE WORLD HEALTH ORGANIZATION: A STUDY IN DECENTRALIZED INTERNATIONAL ADMINISTRATION (1957).

[121] *See* Socrates Litsios, *The Health, Poverty, and Development Merry-Go-Round: The Tribulations of WHO*, *in* UNDERSTANDING THE GLOBAL DIMENSIONS OF HEALTH 15, 20–23 (S. William et al. eds., 2005).

[122] *See* Ascher, *supra* note 25.

focus of human rights and moved toward curative health care, heightened by a sense of unlimited possibility for the advancement of science—a sense that all the world's ills could be solved by the hand of the knowing physician, operating one person at a time through the tools of medicine.[123] Given this medicalized conception of health care, rooted in the "golden age of medicine" and the scientific spirit of the post-War era, achievements through medical progress led developed countries to gradually lose interest in global health issues and national public health systems in the years following World War II.[124] Ignoring previously-recognized societal determinants of health,[125] international development organizations—driven by the larger "medical-industrial complex" that had sprung from the War—furthered this biomedical vision of health, emphasizing antibiotics, medical technologies, and private urban hospitals as a means to achieve economic growth.[126]

WHO came to accept this medicalized view of health, pursuing vertical programs for the individual medical treatments then thought to be singularly necessary for achieving the highest attainable standard of health.[127] Rather than working with states to develop comprehensive public health systems, the WHO Secretariat merely trained local health ministries in medical techniques, with the Director-General viewing WHO personnel as "catalyst[s] . . . who, working on projects, pass on to their national counterparts the skill and knowledge needed to attack a specific health problem."[128] Based on the early success of WHO's state coordination to combat Yaws (a crippling communicable disease characterized by skin lesions and swelling of the joints) through the dissemination of penicillin, WHO's disease-specific "Yaws approach" sought technical medical solutions to individual ailments.[129] In light of this WHO view that technologies would inevitably lead diseases to be eradicated, the World Health Assembly focused its attention on assuring the fleeting provision of medical supplies[130]—rather than the sustainable frameworks of public health systems—with WHO Secretariat staff providing technical assistance to national governments in the absence of international cooperation and national legislation. Enacted independently by WHO regional offices, such technical assistance to national governments would focus on advice in health services, demonstrations of modern medical practices, and training of medical practitio-

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[123] *See* Dorothy Porter, *The Decline of Social Medicine in Britain in the 1960s*, *in* SOCIAL MEDICINE AND MEDICAL SOCIOLOGY IN THE TWENTIETH CENTURY 97, 97–113 (Dorothy Porter ed., 1997).

[124] *See* NEVILLE M. GOODMAN, INTERNATIONAL HEALTH ORGANIZATIONS AND THEIR WORK 147–148 (2d ed. 1971).

[125] *See* Mervyn Susser, *Ethical Components in the Definition of Health*, 4 INT'L J. HEALTH SERVICES 539, 541 (1974).

[126] *See* EDWARD S. GOLUB, THE LIMITS OF MEDICINE: HOW SCIENCE SHAPES OUR HOPE FOR THE CURE 215 (1994).

[127] *See* CHARLES O. PANNENBORG, A NEW INTERNATIONAL HEALTH ORDER: AN INQUIRY INTO THE INTERNATIONAL RELATIONS OF WORLD HEALTH AND MEDICAL CARE 186 (1979).

[128] Marcolino G. Candau, *World Health Catalysts*, 47 AM. J. OF PUB. HEALTH 675, 676 (1957), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1551052/pdf/amjphnation01089-0001.pdf.

[129] *See* John W. Peabody, *An Organizational Analysis of the World Health Organization: Narrowing the Gap Between Promise and Performance*, 40 SOC. SCI. & MED 731, 735–36 (1995).

[130] *E.g.*, World Health Assembly, *Draft Requirements for Good Manufacturing Practice in the Manufacture and Quality Control of Drugs and Pharmaceutical Specialties* (1968). (on file with author).

ners.[131] Under such a framework for the practice of international health, there was little room for legal rights in disease prevention and health promotion.

Thus, with WHO approaching health in a functional, instrumental way, "[f]ulfilling its mandate was not done from a rights perspective nor with the aim of setting standards to be met by states."[132] As a result, WHO faced emasculation of its human rights authority, and the right to health suffered attenuation in its state obligations. When it came time for WHO to chronicle the first ten years of its own existence, no mention was made of its previous leadership in developing human rights norms or its previous cooperation with the Commission on Human Rights, emphasizing only its cooperation with ECOSOC in "activities having a direct bearing on certain public-health or medical questions of technical significance."[133] Ten years later, when WHO again sought to review its achievements in international public health, only token reference was made to human rights, with the Director-General merely noting in vague, prefatory language that "people are beginning to ask for health, and to regard it as a right."[134] People were in fact asking for health, but WHO would not construe it as a right, stymieing the advancement of human rights for the public's health.

Throughout 1953, the Commission on Human Rights sought to finalize the language of the right to health for inclusion in the ICESCR, with ECOSOC requesting that the Commission continue to reach out to specialized agencies for their observations on the final drafting.[135] However, in WHO's September 1953 response to the Commission's request for observations, WHO's Director-General declined to make any observations, responding only with empty rhetoric and noting simply, "I have no particular comment to offer on this report."[136] Where other specialized agencies submitted lengthy responses describing their final positions on relevant articles, WHO communicated simply by referring to previously produced technical documents, many of which had no bearing on human rights norms.[137] Although specialized agencies were asked to submit correspondingly detailed comments on their human rights reporting procedures, WHO responded in December 1953 with far fewer comments relative to other agencies, requesting only that simpler reporting procedures be instituted.[138]

After six sessions (1949-1954) devoted almost entirely to translating the UDHR into legally-binding obligations, the Commission on Human Rights concluded its preliminary work on the draft Covenant on Civil and Political Rights and the draft Covenant on Economic, Social, and Cultural Rights, with the debate then

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[131] *See* Henry van Zile Hyde, *The Nature of the World Health Organization*, 68 PUB. HEALTH REP. 601, 603–04 (1953).

[132] Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 45 (1994).

[133] WHO, THE FIRST TEN YEARS OF THE WORLD HEALTH ORGANIZATION 59 (1958).

[134] WHO, THE SECOND TEN YEARS OF THE WORLD HEALTH ORGANIZATION ix (1968).

[135] *See* ECOSOC Res. 501 B (XVI), at 10, U.N. Doc. E/2508 (Aug. 3, 1953).

[136] Letter from M.G. Candau, Dir.-Gen., WHO, to Guillaume Georges-Picot, Assistant Sec'y-Gen., U.N. (Sept. 22, 1953) (on file with author).

[137] *See* The Secretary-General, *Draft International Covenant on Human Rights and Measures of Implementation: Existing Procedures for Periodic Reporting to Specialized Agencies, delivered to ECOSOC*, U.N. Doc. E/CN.4/590/Add.5 (Dec. 9, 1953).

[138] Letter from M.G. Candau, Dir.-Gen., WHO, to Guillaume Georges-Picot, Assistant Sec'y-Gen., U.N. (Nov. 9, 1953) (on file with author).

moving to the U.N. General Assembly to review these covenants and over 12,000 pages of accompanying documentation.[139] To prepare for this debate, the U.N. Secretary-General requested that the Division of Human Rights devote a full year to preparing an analytical summary of the comments and discussions on the preambles and articles of both covenants.[140] The resulting summary, "Annotations on the Text of the Draft International Covenants on Human Rights," provides analysis of the *travaux préparatoires* of the draft covenants, laying out the main points of substance and remaining questions for consideration by member states.[141] On the topic of the right to health, then Article 13 of the draft Covenant on Economic, Social, and Cultural Rights, the U.N. summary reflected WHO's early contributions, recognizing that "[i]n the drafting of the text of article 13, which is more detailed than the preceding articles, consideration was given to the attitude of the World Health Organization (WHO), which favoured the inclusion in the article of a certain degree of detail."[142] Notwithstanding this praise for WHO's early leadership, the summary also reflected WHO's subsequent failures, including a discussion of continuing disputes on the inclusion of: (1) a definition of complete health; (2) the idea of "social well-being;" and (3) the "steps to be taken" in the second paragraph for underlying determinants of health.[143] Although WHO was given the first six months of 1955 to review and comment on this summary of the draft International Covenants on Human Rights,[144] WHO never provided any comments, and the criticisms presented in the U.N.'s annotations were sent unchallenged to the General Assembly.

When the finalization of the right to health moved to the Third Committee of the General Assembly in 1957, WHO had lost credibility to effect change within the U.N. Secretariat and among state delegations. As delegates summarily eliminated the definition of health from the human right, under the contradictory rationales that the definition was either unnecessarily verbose or irreconcilably incomplete, WHO personnel made little attempt to prevent this deletion. Despite WHO's previous argument that the definition accounted for the relationship between underlying determinants of health and disease, a causal link that states had implicitly adopted through the WHO Constitution, state amendments prevailed in eliminating from the right to health both a definition of health and any reference to "social well-being."[145] In addressing the "measures to be taken" in paragraph 2, additional changes to the language were made—largely at the insistence of other specialized

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[139] *See* Memorandum from Egon Schwelb, Acting Dir., Div. of Human Rights, U.N., to Guillaume Georges-Picot, Assistant Sec'y-Gen., U.N. and John P. Humphrey, Acting Principal Dir., Dep't of Soc. Affairs, U.N., *Draft Covenants on Human Rights* (Apr. 23, 1954) (on file with author).

[140] *See* G.A. Res. 833 (IX), at 20, U.N. Doc. A/2890 (Dec. 4, 1954).

[141] *See* The Secretary-General, *Draft International Covenants on Human Rights. Annotation Prepared by the Secretary-General, delivered to the General Assembly*, U.N. Doc. A/2929 (July 1, 1955); *see also* Memorandum from Egon Schwelb, Acting Dir., Div. of Human Rights, U.N., to John P. Humphrey, Acting Principal Dir., Dep't of Soc. Affairs, U.N., *Draft International Covenants on Human Rights: Implementation of G.A. Resolution of 4 December 1954* (Dec. 9, 1954) (on file with author).

[142] GAOR, Austria, U.S.S.R., & U.K., *Draft International Covenants on Human Rights. Observations by Governments*, U.N. Doc. A/2910/Add.1 (July 27, 1955).

[143] *Id.*

[144] *See* Letter from P.M. Kaul, Dir. of Offices of External Relations & Tech. Assistance, WHO, to Philippe de Seynes, Under-Sec'y, Dep't of Econ. & Soc. Affairs, U.N. (Jan. 18, 1955) (on file with author).

[145] *See* G.A. Res. 1041 (XI), at 19–20, U.N. Doc. A/C.3/L.589 (1957).

agencies—including: (1) the inclusion in 2(a) of "stillbirth;" (2) the weakening in 2(b) of "the improvement of nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene" with the less-specific "improvement of all aspects of environmental and industrial hygiene;" and (3) the addition in 2(c) of "occupational diseases."[146] Abandoning its efforts to strengthen health rights, WHO took little part in the concluding debates relative to other specialized agencies.[147] With debate on the right to health ending in a failed effort to put limitations on compulsory treatment,[148] no amendments were offered to expand the positive obligations of this enfeebled right.

On January 30, 1957, the Third Committee of the General Assembly voted in favor of this amended right to health (54–0, with 7 abstentions), thereafter re-numbering the right from Article 13 to Article 12 but otherwise leaving the right to health as it was upon finalization of the ICESCR in 1966:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> > (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> > (b) The improvement of all aspects of environmental and industrial hygiene;
> > (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> > (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[149]

Although subsequent changes were made to strengthen other articles of the ICESCR, some in response to arguments from specialized agencies (e.g., FAO's successful 1963 proposal that led to article 11(2) on a right to food)[150], WHO made no additional comments on the right to health, and U.N. delegates made no substantive changes to Article 12.

As the U.N. moved from the substantive articles of the ICESCR to its measures of implementation, the Commission on Human Rights again sought the opinions of specialized agencies, which were expected to serve a crucial role as im-

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[146] Draft International Covenants on Human Rights: Belgium's Sub-Amendment to the Amendments of Afghanistan and the Philippines, U.N. GAOR, 11th Sess., 764th mtg., U.N. Doc. A/C.3/L.593 (Jan. 30, 1957).

[147] *See* ECOSOC, *Social, Humanitarian and Cultural Questions*, 13 INT'L ORG. 99 (1959).

[148] *See* U.N. GAOR, 11th Sess., 747th mtg., U.N. Doc. A/C.3/SR.747 (Jan. 30, 1957).

[149] Memorandum from John P. Humphrey, Dir., Div. of Human Rights, U.N., to Philippe de Seynes, Under-Sec'y, Dept. of Econ. & Soc. Affairs, U.N., *747th Meeting of the Third Committee* (Jan. 31, 1957) (on file with author).

[150] *See* KATARINA TOMASEVSKI, THE RIGHT TO FOOD: GUIDE THROUGH APPLICABLE INTERNATIONAL LAW 34–35 (1987).

plementing agencies under the ICESCR.[151] In the case of WHO, however, these implementation discourses would be in vain. Beginning in 1956 under a General Assembly program to create advisory services in the field of human rights,[152] WHO Director-General Candau responded that WHO had "no comments to offer concerning new measures which would be necessary with a view to assisting Member States in furthering the effective observance of the right to health."[153] Despite subsequent U.N. efforts in the 1960s to provide an official role for specialized agencies in implementing the ICESCR, the only area in which WHO participated with the Commission on Human Rights was to reduce its reporting expectations. Reflecting the limitations of WHO's International Digest of Health Legislation as a mechanism for monitoring state health policy, WHO's 1962 response did little more than vitiate its 1953 policy statement that each state "communicates promptly to the Organization important laws,"[154] regressing to the statement that "an account of the health legislation of *as many member States as possible* is given in the quarterly WHO publication: The International Digest of Health Legislation."[155] In consideration of far more robust responses from other specialized agencies (on clarifying norms, developing specific standards, promoting the realization of rights, and monitoring state performance), the U.N. agreed that that it would encourage state human rights reporting to specialized agencies and that the U.N. Secretariat would pursue studies on the national legislation needed to implement the covenants. Although the ICESCR provided authority for specialized agencies to submit reports to the U.N. on the progressive implementation of the Covenant, well over a decade of reports by other specialized agencies would pass before WHO submitted its first report.[156] Despite the fact that the ICESCR provides authority for the U.N. to submit state reports to specialized agencies on issues that fall within the agencies' respective fields of competence,[157] the U.N. did not send reports to WHO. With scholars noting that "the implementation procedure is directed at the agencies" and arguing that "agencies have a fundamental responsibility to promote realization of rights," WHO made no specific commitments and took no programmatic action to implement the right to health.[158]

Even once the ICESCR was adopted and opened for signature in December

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[151] *See* Egon Schwelb, *Notes on the Early Legislative History of the Measures of Implementation of the Human Rights Covenants*, *in* MÉLANGES OFFERTS À POLYS MODINOS: PROBLÈMES DES DROITS DE L'HOMME ET DE L'UNIFICATION EUROPÉENNE 270, 270–89 (1968).

[152] *See* G.A. Res. 926 (X), at 13, U.N. Doc. A/RES/10/926 (Dec. 14, 1955).

[153] Letter from M.G. Candau, Dir.-Gen., WHO, to U. Thant, Sec'y-Gen., U.N. (Feb. 27, 1956) (on file with author).

[154] Letter from P. Dorolle, Deputy Dir.-Gen., WHO, to C.V. Narasimhan, Chef de Cabinet, U.N. (Aug. 7, 1962) (on file with author).

[155] The Secretary-General, *Draft International Covenants on Human Rights: Existing Procedures for Periodic Reporting to Specialized Agencies*, at 14, *delivered to the General Assembly*, U.N. Doc. A/C.3/L.1015 (Oct. 31, 1962) (emphasis added).

[156] *See* David M. Trubek, *Economic, Social, and Cultural Rights in the Third World: Human Rights Law and Human Needs Programs*, *in* HUMAN RIGHTS IN INTERNATIONAL LAW: LEGAL AND POLICY ISSUES 205 (Theodor Meron ed., 1984).

[157] *See* International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), Supp. No. 16, Art. 40(3), U.N. GAOR, 21st Sess., U.N. Doc. A/6316 (Dec. 16, 1966) [hereinafter ICESCR].

[158] Alston, *supra* note 38, at 117.

1966,[159] WHO claimed no ownership or responsibility over the new Covenant's obligations on health, noting in its records that:

> In response to a question from Mr. Schreiber [Director, U.N. Division of Human Rights] as to assistance of WHO in advocating ratifications of the covenants on economic, social and cultural rights, it was pointed out that acceptance of the WHO Constitution covers this matter fully in health terms and WHO could not press its Member States with respect to the covenants.[160]

With states moving independently to adopt the ICESCR, translating its international obligations into national law and national law into public health practice, WHO was silent on its role in promoting and implementing the right to health.

As the years passed, WHO's continued neglect for health rights in international treaty frameworks eliminated public health advocates' opportunities to clarify the scope and content of health rights, leaving Article 12's imprecise elaboration of the right to health as the seminal, final, and definitive international legal obligation pursuant to this right:

- As the Council of Europe sought the assistance of U.N. specialized agencies in 1958 to codify economic and social rights in its own regional treaty, the European Social Charter, WHO declined to respond, with the Council of Europe subsequently reaching out only to the ILO, which took an active role to finalize this regional treaty.[161]
- In 1959 debates on a draft declaration of the rights of the child, although the U.N. Secretariat welcomed WHO comments in the process, the WHO liaison to the Commission on Human Rights received instructions from WHO headquarters to offer only general "support,"[162] and did not to make any statement or offer any substantive comments.[163]
- When the U.N. General Assembly began work in 1964 on a draft declaration on the elimination of discrimination against women,[164] WHO considered this to be outside its mandate, reasoning that the "non-discrimination clause" in the WHO Constitution "[does] not refer to discrimination on account of sex."[165] As a result, WHO responded that because it "is not entrusted with responsibility for direct action to overcome such restrictions," it was "not possible to derive from the work of WHO principles that might

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159 *See* ICESCR, *supra* note 157.

160 WHO, *Notes for the Record: Meeting with Mr. Marc Schreiber, Director, United Nations Division of Human Rights on Friday, 5 May 1972* (May 29, 1972) (on file with author).

161 *See* ROSCAM ABBING, *supra* note 35, at 77–88.

162 *See* Memorandum from PHA Section to P.M. Kaul, Assistant Dir.-Gen., WHO, *Human Rights Commission, 15th Session, Rights of the Child* (Jan. 28, 1959) (on file with author).

163 *See* Memorandum from Michael Sacks, Dir., U.N. Liaison Office, WHO, to P. Dorolle Deputy Dir.-Gen., WHO, *Report on the Fifteenth Session of the Commission on Human Rights* (Apr. 21, 1959) (on file with author).

164 *See* G.A. Res. 1921 (XVIII), at 41, U.N. Doc. A/5606 (1963).

165 Memorandum from F. Gutteridge, Dir., Legal Office, WHO, to P. Dorolle, Deputy Dir.-Gen., WHO, *Discrimination Against Women* (Feb. 12, 1964) (on file with author).

be incorporated into a draft declaration."[166]

- After U.N. entreaties to participate in the 1965 development of a convention on the elimination of all forms of racial discrimination, WHO responded dismissively that while legislation is "outside its competence," its technical programs "may be said to give effect to the principle of non-discrimination," blithely submitting that:

  > [W]hile public information publications of WHO rarely have occasion to say anything directly against racial discrimination, they breathe a spirit of equality and are intended, by their universal treatment of many topics, by showing people as people wherever they may live, to help the advancement of human rights and the improvement of race relations.[167]

As a result, health discrimination and inequities in health care—while forming a contemporaneous impetus for Martin Luther King's invocation, "of all the forms of inequality, injustice in health care is the most shocking and inhumane"—would not be a part of the international human rights debate, with WHO arguing to the U.N. Division of Human Rights as late as 1972 that "it was not the feeling of WHO that a segmental [race-based] approach would be useful . . . in the field of health."[168]

In the midst of this noncooperation in human rights development, WHO staff also engaged in a coordinated campaign to distance the organization from any U.N. responsibilities in human rights implementation, specifically attempting to shirk its reporting requirements with the Commission on Human Rights.[169] Initially believing the WHO Secretariat to be under an unavoidable obligation to cooperate in human rights reporting, WHO staff were concerned in 1956 that because WHO "co-operated with the Human Rights Commission in preparing the draft Covenant on Human Rights, its failure to act under the Resolution on Annual Reports might be interpreted as obstructive."[170] Despite this internal debate on WHO cooperation, Director-General Candau's February 1957 response to the U.N. simply announced that "the Organization, not being entrusted with safeguarding legal rights, is not in a position to take a share in a report describing developments and progress achieved during the years 1954-1956 in the field of human rights and measures taken to safeguard human liberty."[171] When the Commission on Human Rights met in 1958 to review country and specialized agency reports, Commission members, while commending other specialized agencies for their work on these reports, took strenuous

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[166] Letter from P. Dorolle, Deputy Dir.-Gen., WHO, to John P. Humphrey, Dir., Div. of Human Rights, U.N. (Feb. 17, 1964).

[167] Letter from L. Bernard, Assistant Dir.-Gen., WHO, to John P. Humphrey, Dir., Div. of Human Rights, U.N. (Dec. 16, 1965) (on file with author).

[168] WHO, *Notes for the Record: Meeting with Mr. Marc Schreiber, Director, United Nations Division of Human Rights on Friday, 5 May 1972*, *supra* note 160.

[169] *See* ECOSOC Res. 624B (XXII), U.N. Doc. E/2928 (Aug. 14, 1956).

[170] Memorandum from B. Howell, Liaison to the U.N., WHO, to P.M. Kaul, Dir., Offices of External Relations & Tech. Assistance, WHO, *Human Rights Commission Twelfth Session Resolution on Annual Reports* (Apr. 27, 1956) (on file with author).

[171] Letter from M.G. Candau, Dir.-Gen., WHO, to Martin Hill, Deputy Under-Sec'y for Econ. & Soc. Affairs, U.N. (Feb. 19, 1957) (on file with author).

objection to WHO's statement.[172] In particular, the French Representative, René Cassin (a progenitor of the UDHR who would later be awarded the Nobel Peace Prize for his human rights work), expressed his personal disappointment and implored the WHO representative to comply with WHO's duty to report on its activities, suggesting reports on: (1) medical care for the sick and their social protection; (2) dangerous experiments with new drugs; (3) cruel and inhuman experiments on healthy subjects and the plight of survivors of Nazi experimentation; and (4) protection against dangerous radiation.[173] Although the WHO representative then promised the Commission that WHO would soon transmit to it the forthcoming First Report on the World Health Situation, WHO subsequently noted in meetings with U.N. Secretariat staff that this Report would be irrelevant in considering a right to health:

> I said that WHO was quite ready to co-operate with the Commission, in spite of some reproaches we have received. But we are anxious that the work we do should bring real benefits to governments and we are not sure how governments would profit from having the Human Rights Commission discuss reports on health . . . . Legal measures, which are the Commissions' [sic] main concern, cannot "enforce" health—what counts in health is the *means* for putting laws into effect.[174]

Consequently, WHO informed the U.N. Division on Human Rights that while it would submit its Report on the World Health Situation, the U.N. Secretariat need not include a section on health in its human rights summaries.[175] Unwilling to accept this, the U.N. Secretariat insisted that WHO provide at least "a succinct statement . . . on the progress achieved in the realization of the right to health, on the basis of the First Report on the World Health Situation."[176] Compelled to respond, WHO's eventual 1959 report to the Commission on Human Rights included simply a reproduction of those chapters of the Report on the World Health Situation that related to medical care,[177] ignoring any relevance of this information to the realization of the right to health.

In the wake of these tensions, WHO attempted to remove itself entirely from the human rights reporting process and measures of progress in the protection of human rights. When the U.N. Secretary-General proposed in 1959 that member

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[172] *See* Memorandum from P. Bertrand, Assistant Dir.-Gen., WHO, to P. Dorolle, Deputy Dir.-Gen., WHO, *Participation de L'oms aux Rapports Periodiques sur les Droits de L'Homme* (July 23, 1958) (on file with author).

[173] *See* ECOSOC, Comm'n on Human Rights, *Draft Report of the Fourteenth Session of the Commission to the Economic and Social Council*, U.N. Doc. E/CN.4/L.477/Add.4 (Apr. 2, 1958) (on file with author).

[174] *See* Memorandum from B. Howell, Liaison to the U.N., WHO, to P. Bertrand, Assistant Dir.-Gen., WHO, *Periodic Reports on Human Rights: Notes of Conversation with Mrs. Bruce of the U.N. Department of Human Rights on 4 July 1958* (July 7, 1958) (on file with author).

[175] *Id.*

[176] Letter from Humphrey Trevelyan, Under-Sec'y in Charge of Special Pol. Affairs, U.N., to P. Dorolle, Deputy Dir.-Gen., WHO (Aug. 21, 1958) (on file with author).

[177] *See* Memorandum from Michael Sacks, Dir., U.N. Liaison Office, WHO, to P. Dorolle, Deputy Dir.-Gen., WHO, *Periodic Reports on Human Rights: Your Cable No. 6 of 4 February and Your Letter of 5 February 1959* (Feb. 9, 1959) (on file with author).

states report directly to specialized agencies on the human rights within their purview, noting explicitly that states should report to WHO on matters relating to the right to health (as set forth in [A]rticle 25 of the UDHR),[178] the WHO Secretariat successfully demanded that the U.N. delete any mention of WHO in its proposal. Arguing that Article 25 dealt far more with "social questions" than with health, WHO suggested that the U.N. would be the only appropriate reviewing agency for Article 25 of the UDHR.[179] At the request of the U.N. Division of Human Rights, the WHO Secretariat formalized this position in writing, stating that "the provisions contained in Article 25 of the Declaration, in their letter and spirit, go substantially beyond the competence of the World Health Organization and would therefore not lend themselves to a direct reporting by Governments to this Organization,"[180] repeating its position under withering criticism from the 1959 session of the Commission on Human Rights.[181] With the U.N. declining to request future WHO comments on human rights reports and WHO resisting all subsequent efforts to submit triennial human rights reports to the U.N.,[182] the U.N. Secretary-General's 1968 review of efforts taken by specialized agencies in the field of human rights includes only a vague generality on the right to health—that "[t]hrough its programme of technical assistance, WHO is helping countries achieve the objectives set forth in the preamble to its constitution, and thus the full range of its activities are relevant to human rights by assisting countries to make a reality of their people's right to health."[183] Further reflecting WHO's absence, the U.N. Secretary-General's comprehensive 1968 report on "Measures and Activities Undertaken in Connexion with the International Year of Human Rights" included activities taken by all specialized agencies except WHO (ILO, FAO, UNESCO, International Telecommunication Union, Universal Postal Union, and the World Meteorological Organization),[184] leading WHO to rectify a perceived slight of its informational activities[185] by making an official statement to the U.N. General Assembly "expanding on the concept

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178 The Secretary-General, *Periodic Reports on Human Rights*, *delivered to the Economic and Social Council Commission on Human Rights*, ¶ 2, U.N. Doc. E/CN.4/776/Add.2 (Mar. 6, 1959).

179 *See* Memorandum from P. Dorolle, Deputy Dir.-Gen., WHO, to B. Howell, Liaison to the U.N., WHO, *Rapports Periodiques sur les Droits de L'Homme* (Feb. 5, 1959) (on file with author).

180 Letter from P. Dorolle, Deputy Dir.-Gen., WHO, to John P. Humphrey, Dir., Div. of Human Rights, U.N. (Feb. 24, 1959) (on file with author).

181 *See* Memorandum from Michael Sacks, Dir., U.N. Liaison Office,WHO, to P. Dorolle, Deputy Dir.-Gen., WHO, *Report on the Fifteenth Session of the Commission on Human Rights* (Apr. 21, 1959) (on file with author).

182 *See* Letter from A. Bellerive, Dir., Div.of Co-ordination and Evaluation, WHO, to M. Schreiber, Dir., Div. of Human Rights, U.N., Ref. SO 214 (2–1–2) 1965–68 (July 11, 1968) (on file with author); Letter from L. Bernard, Assistant Dir.-Gen., WHO, to E. Lawson, Deputy Dir., Div. of Human Rights, U.N., Ref. SO 214 (2–1–2) 1965–1967 (Oct. 4, 1965) (on file with author); Letter from L. Bernard, Assistant Dir.-Gen., WHO, to M. Schreiber, Dir., Div. of Human Rights, U.N., Ref. SO 214 (2–3–2) 1963–66 (Sept. 23, 1966) (on file with author); Letter from P. Dorolle, Deputy Dir.-Gen., WHO, to John P. Humphrey, Dir., Div. of Human Rights, U.N. Ref. N64/180/5 (Feb. 7, 1963) (on file with author); Letter from P. Dorolle, Deputy Dir.-Gen., WHO, to C.V. Narasimhan, Under-Sec'y for Special Political Affairs, U.N., Ref. SO 214 (2–1–2) (July 11, 1960) (on file with author).

183 UNITED NATIONS, THE UNITED NATIONS AND HUMAN RIGHTS (1968).

184 The Secretary-General, *Measures and Activities Undertaken in Connexion with the International Year for Human Rights*, 74–83, *delivered to the* General Assembly, U.N. Doc. A/7195 (Sept. 24, 1968).

185 *See* Letter from L. Bernard, Assistant Dir.-Gen., WHO, to Michael Sacks, Dir., U.N. Liaison Office, WHO, *International Year for Human Rights*, U.N. Ref. N64/180/5 (b) (Oct. 10, 1968) (on file with author).

of man's right to health."[186] But without any sustained WHO participation in the development or implementation of human rights, health rights would be left without normative frameworks and accountability standards from the world's preeminent health agency, denying states the guidance necessary to realize underlying determinants of health pursuant to the human right to health.

C. WHO Rediscovers Human Rights (1973-1980) – The Declaration of Alma-Ata as a Rights-Based Approach to Health

By the early 1970s, however, there was a return to the promise of international human rights standards as a means to achieve global health policy. Concurrent with the expansion of broader human rights movements,[187] human rights organizations,[188] and human rights instruments,[189] WHO would seek to expand its influence by redefining its health goals to reflect human rights standards. Within the U.N. system, increased human rights coordination among specialized agencies buttressed WHO efforts,[190] providing added collaborative opportunities for human rights advancement in health.[191] After years of absence, WHO reemerged in 1973—at the Commission on Human Rights, in human rights seminars, and as a voice for social justice. In doing so, WHO leadership would hold out human rights as a force for health, using international negotiations, articles, and conferences to promote the relevance of health rights to public health policy and extolling human rights obligations as a clarion call to the attainment of health for all.

Understandings of health had changed dramatically in the twenty-five years since the founding of WHO. With public health realities bringing an end to the unfulfilled promise of the golden age of medicine, theories for "preventive medicine" had gained credibility in health discourse and showed far greater promise in ameliorating communicable, acute, and chronic disease. By focusing on the correlations among increasing poverty, inequality, and ill-health,[192] the perceived emergence of new threats—in the form of heart disease, cancer, labor migration and exploitation, drug addiction, overpopulation, and environmental harms—was shifting public health toward an emphasis on the prevention of social, "lifestyle" determi-

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[186] Memorandum from Michael Sacks, Dir., U.N. Liaison Office, WHO, to L. Bernard, Assistant Dir.-Gen., WHO, at 2 (Dec. 31, 1968) (on file with author).

[187] *See* Jack Donnelly, *International Human Rights: A Regime Analysis*, 40 INT'L ORG. 599, 633–39 (1986).

[188] *See* Kiyoteru Tsutsui & Christine Min Wotipka, *Global Civil Society and the International Human Rights Movement: Citizen Participation in Human Rights International Nongovernmental Organizations*, 83 SOC. FORCES 587, 593 (2004).

[189] *See* Rennie Moon, From Charity to Human Right: Discourse and Global Expansion of Health and Health Education, 1650–1997 (2003) (unpublished Master's thesis, Stanford University), *available at* http://www.stanford.edu/dept/SUSE/ICE/monographs/Moon.pdf.

[190] *See* Administrative Committee on Coordination, *Annual Report of the Administrative Committee on Co-ordination for 1973–74*, U.N. Doc. E/5488 (May 20, 1974).

[191] *See* The Secretary-General, *Further Promotion and Encouragement of Human Rights and Fundamental Freedoms*, U.N. Doc. E/CN.4/1193 (Jan. 28, 1976); The Secretary-General, *Further Promotion and Encouragement of Human Rights and Fundamental Freedoms, Including the Question of the Programme and Methods of Work of the Commission*, U.N. Doc. E/CN.4/1433 (Dec. 16, 1981).

[192] *See* BIPLAB DASGUPTA & DUDLEY SEERS, STATISTICAL POLICY IN LESS DEVELOPED COUNTRIES (Univ. of Sussex, Inst. Of Dev. Studies 1975).

nants of disease.[193] With the rise of industrialized cities across the globe, scholars began to note that "[o]ne consequence of the explosive growth of large cities and the urban sprawl is that the old problems of air, water, and food pollution are reappearing everywhere with new and intensified manifestation."[194] Compounded by the 1969 arrival of "Hong Kong influenza"—highlighting the pathways by which new harms could spring from crowded cities, spreading thereafter throughout the world[195]—scholars focused more intently on the role of weak national health systems in enabling the spread of disease.[196] With an understanding that advances in medical care had neither promoted health nor prevented disease at a global level, scholars turned their attention from nostrums to environments.[197]

In this shift, it became clear that there exist structural determinants of health—political and socio-economic factors that have far greater sway than medicine on individual and public health.[198] Through this appreciation of the systemic, distal social conditions that underlie health inequalities, public health practitioners reengaged underlying determinants of health, drawing on theories of social medicine and recognizing a "need for a shift in the balance of effort [to] modification of the conditions which led to disease rather than from intervention in the mechanism of disease after it has occurred."[199] Given a growing gap between what could be done and what was being done to address these underlying health determinants, scholars and practitioners began to examine national health systems, including administration and financing decisions beyond the individual delivery of health services, and to expand their view of public health beyond the role of the physician, encompassing a range of health personnel and infrastructures.[200]

Through this growing consensus in public health, WHO began in the late 1960s to make the development of national health systems a principal component of its technical assistance and cooperation, with WHO focusing on assisting states in the formulation of national health strategies and the incorporation of these health strategies into national plans for social and economic development.[201] WHO's previous health planning had simply promoted the export of Western medical models to the developing world, diverting health resources from public health programs to urban medical facilities specializing in curative care—often caring for wealthy el-

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[193] *See* George L. Engel, *The Need for a New Medical Model: A Challenge for Biomedicine*, 196 SCIENCE 129, 131–32 (1977).

[194] RENÉ J. DUBOS, MAN ADAPTING 237–38 (1965).

[195] *See Communicable Diseases in 1969*, 24 WHO CHRON. 259, 269 (1970).

[196] *See* Socrates Listios, *The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach,* 94 AM. J. PUB. HEALTH 1884, 1885 (2004) (citing Socrates Litsios, A Programme for Research in the Organization and Strategy of Health Services (unpublished paper presented at the WHO Director General's Conference) (June 25, 1969)).

[197] *See* Aaron Wildavsky, *Doing Better and Feeling Worse: The Political Pathology of Health Policy*, *in* DOING BETTER AND FEELING WORSE 105 (1977).

[198] *See* GEORGE ROSEN, FROM MEDICAL POLICE TO SOCIAL MEDICINE: ESSAYS ON THE HISTORY OF HEALTH CARE 116–17 (1974); Nevin S. Scrimshaw, *Myths and Realities in International Health Planning*, 64 AM. J. PUB. HEALTH 792, 792–93 (1974).

[199] THOMAS MCKEOWN, THE ROLE OF MEDICINE: DREAM, MIRAGE, OR NEMESIS? 179 (1976).

[200] Karl Evang, *Human Rights: Health for Everyone*, 26 WORLD HEALTH 3, 5–6 (1973).

[201] Sir John Charles, *Origins, History and Achievements of the World Health Organization*, BRIT. MED. J., May 4, 1968, at 293–96.

ites rather than those in greatest need.[202] For developing states, "it became obvious that many of them needed assistance in strengthening their health services in general, not merely for specific disease campaigns requiring the use of new technologies."[203] With the failures of early disease eradication programs (e.g., the end of WHO's global malaria campaign)[204] and successes of national health promotion systems (e.g., China's "barefoot doctors," seen as a means to transform the wellbeing of rural populations),[205] WHO's technical documents transitioned in the late 1960s from a persistent faith in a vertical, disease-specific approach to health to an increased emphasis on horizontal "primary health care"[206]—a longstanding undercurrent in health scholarship and advocacy, addressing health care in addition to social, political, and economic underlying determinants of health.[207] Under these early examinations of primary health care systems, WHO would establish: (1) a 1967 epidemiological study of health services planning; (2) a 1969 program in Project Systems Analysis, and; (3) a 1972 Secretariat study to the Executive Board on the organization of basic health services.[208] These programs and studies would seek to reorient WHO's work to assist states in developing primary health care, organizing country-specific comprehensive national plans to integrate disease prevention and health promotion through its newly-formed WHO Secretariat Division, Strengthening of Health Services.[209] WHO's Fifth General Programme of Work, beginning in 1973, would officially shift WHO policy toward establishing national health promotion programs through primary health care, including programs for: (1) strengthened health services; (2) disease prevention and control; (3) promotion of environmental health; (4) health manpower and development, and; (5) improved research capacity.[210] In implementing this Programme, WHO would reorient its activities—programmatically (from selective medical services to equitable primary health systems) and geographically (from Europe to developing countries).[211]

In translating these public health discourses into international legal norms, WHO came to recognize that human rights obligations could bind states to realize the health of their peoples. While a horizontal approach to public health had long garnered technical support within WHO, only ideological support could bring these evolving health discourses to the fore of global health policy.[212] In providing early

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[202] *See* WHO, INTERRELATIONSHIPS BETWEEN HEALTH PROGRAMMES AND SOCIOECONOMIC DEVELOPMENT (1973); Halfdan Mahler, Dir.-Gen., WHO, Statement to the Second Session of the Ad Hoc Committee: The Restructuring of the United Nations in the Economic and Social Sectors (Feb. 13, 1976).

[203] L.A. Kaprio, Dir., WHO Reg'l Office for Eur., Address to the 19th International Hospital Congress: Recent Trends in Health Service Patterns, Zagreb, at 8 (June 1976).

[204] *See* EMILIO PAMPANA, A TEXTBOOK OF MALARIA ERADICATION (2d ed. 1969).

[205] *See* Victor W. Sidel & Ruth Sidel, *Self-Reliance and the Collective Good: Medicine in China, in* ETHICS AND HEALTH POLICY 57 (Robert M. Veatch & Roy Branson, eds. 1976).

[206] WHO, THE WORK OF WHO 1966 (1967).

[207] *See* WHO, MEASUREMENT OF LEVELS OF HEALTH: REPORT OF A STUDY GROUP (1957), *available at* http://whqlibdoc.who.int/trs/WHO_TRS_137.pdf.

[208] *See WHO, Executive Bd. 9th Sess., Organizational Study of the Executive Board on Methods of Promoting the Development of Basic Health Services, U.N. Doc. EB49/WP/6 (Jan. 29, 1972).*

[209] *See* Socrates Litsios, *The Long and Difficult Road to Alma-Ata: A Personal Reflection*, 32 INT'L J. HEALTH SERVICES 709, 710 (2002).

[210] *See* World Health Assembly Res. 26.35 (May 1973).

[211] *See* ROSCAM ABBING, *supra* note 35, at 71.

[212] Theodore M. Brown, Marcus Cueto & Elizabeth Fee, *The World Health Organization and the*

ideological backing for WHO, the World Health Assembly pressed the WHO Secretariat in 1970 by resolving that one of the long-term objectives of WHO would be the attainment by all peoples of the highest possible level of health through national health systems, proclaiming as a central tenet of its work:

> The responsibility of the State and society for the protection of the health of the population, to be based on putting into effect a complex of economic and social measures which directly or indirectly promote the attainment of the highest possible level of health, through the establishment of a nation-wide system of health services based on a general national plan and local planning, and through the rational and efficient utilization, for the needs of the health services, of all forces and resources which society at the given stage of its development is able to allocate for those purposes.[213]

With the right to health providing a political foundation for WHO's leadership in global health policy, WHO staff saw in human rights the ability to shift discourse from questions of quality of care through medicine to issues of international development and social justice through health systems.[214] Reflecting the "basic needs" approach of contemporaneous human rights scholars through policies to meet "basic health needs,"[215] the WHO Secretariat would come to advocate for primary health care as a human right and to promote primary health care under its Health for All strategy, as WHO would again take a leading role in developing rights-based health policy.[216]

With the 1973 election of Halfdan Mahler as Director-General, WHO embarked on its Health for All campaign as a means to advance primary health care, seeking specific public health targets to be achieved by the year 2000. Viewing past shifts in national health resources from public health to medicine to be a human rights challenge, Director-General Mahler noted as early as 1974 that "in the context of the universal human right to a socially optimal standard of individual physical and mental health . . . the very sophistication of today's medical wisdom tends to prevent individual and community participation without which health often becomes a technological mockery."[217] This rights-based argument was extended in 1975 to embrace underlying determinants of health, wherein the Director-General's Annual Report argued that:

> We must also remind ourselves that the urgent health problems of developing countries relate to poverty, to infection, to malnutrition and

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Transition from "International" to "Global" Public Health, 96 AM. J. PUB. HEALTH 62, 66 (2006).

[213] World Health Assembly Res. 23.61, Basic Principles for the Development of Health Services (1970).

[214] Allyn Lise Taylor, The World Health Organization and the Right to Health 7 (1991) (unpublished LL.M thesis, Columbia Law School) (on file with author).

[215] *See* V. DJUKANOVIC & E.P. MACH, ALTERNATIVE APPROACHES TO MEETING BASIC HEALTH NEEDS IN DEVELOPING COUNTRIES (1975).

[216] Taylor, *supra* note 214, at 98.

[217] Halfdan Mahler, WHO Dir.-Gen., Address of the Director-General to the 28th World Health Assembly: Further Thoughts on WHO's Mission, *reprinted in* 29 WHO CHRONICLE 254, 254 (1975).

> undernutrition, to lack of accessible potable water, and to multiple environmental hazards. Such basic threats to health are unlikely to be countered by conventional health services techniques [as] . . . too much emphasis must not be placed on health technologies alone. What we can achieve in this field depends directly on the level of economic development of the countries concerned.[218]

This focus led WHO to transition from a growth-based approach to a needs-based approach to development, the latter to be founded upon human rights and driven by the expansion of primary health care.[219] In stark retort to its past identity as a "catalyst" for the dissemination of medical skills, the WHO Secretariat now held itself out as "a catalyst, a world health conscience behind national change, and, when requested, a helper giving visible expression to progressive ideas and decisions within national social policies."[220] Echoing the "basic needs" approach of the U.N.'s focus on a New International Economic Order[221] (a movement seeking to meet the basic needs of a nation's poor through redistributive development),[222] this approach would emphasize primary health care as a means to realize underlying determinants of health and achieve WHO's goal of health for all.[223] This Health for All strategy, defined by the World Health Assembly in 1977 and regarded as WHO's "main thrust" for implementing the right to health,[224] would seek "the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life."[225] With the World Health Assembly viewing the inequitable distribution of resources for health to be a political as well as a technical failure, this Health for All strategy would examine public health within the broader social and economic context of development,[226] seeking the national and international redistributions that would endow all people with the capability to lead socially and economically satisfying lives.[227] Working through the right to health to realize national primary health care systems, this discourse reached its climax in the 1978 Declaration of Alma-Ata. Grounded in concepts of justice, WHO's socio-economic approach to health rights framed the Declaration of Alma-Ata and marked what many considered "the onset of the health revolution."[228] With the Health for All strategy providing a rights-based vision reflective of public health

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[218] HALFDAN MAHLER, INTRODUCTION OF THE DIRECTOR-GENERAL ON THE ACTIVITIES OF THE WORLD HEALTH ORGANIZATION: THE NEW INTERNATIONAL ECONOMIC ORDER 1 (1976).

[219] *See* DJUKANOVIC & MACH, *supra* note 215.

[220] INTRODUCING WHO 80–81 (1976).

[221] Declaration on the Establishment of a New International Economic Order, G.A. Res. 3201, U.N. Doc. A/9559 (May 1, 1974); Andrea Cornwall & Celestine Nyamu-Musembi, *Putting the "Rights-Based Approach" to Development into Perspective*, 25 THIRD WORLD Q. 1415, 1422 (2004).

[222] *E.g.*, D. P. GHAI ET AL., THE BASIC-NEEDS APPROACH TO DEVELOPMENT: SOME ISSUES REGARDING CONCEPTS AND METHODOLOGY 2–3 (1977).

[223] *See* DJUKANOVIC & MACH, *supra* note 215.

[224] Taylor, *supra* note 214, at 14.

[225] World Health Assembly Res. 30.43 (1977).

[226] *See* A. GLENN MOWER, INTERNATIONAL COOPERATION FOR SOCIAL JUSTICE: GLOBAL AND REGIONAL PROTECTION OF ECONOMIC/SOCIAL RIGHTS (1985).

[227] S.W.A. Gunn, The Right to Health Through International Cooperation, *in Il Diritto alla Tutela della Salute: Acts of the International Colloquium on the Right to Health Protection* 20 (1983).

[228] T.A. Lambo, *Towards Justice in Health*, WORLD HEALTH, July 1979, at 2, 4.

discourse, the Declaration of Alma-Ata would provide international consensus for national primary health care systems consistent with WHO's vision of health and human rights.

Setting the stage for this revitalized development of the human right to health, the Hague Academy of International Law collaborated with the United Nations University to sponsor a July 1978 Workshop on the Right to Health as a Human Right.[229] In this setting for its rights-based resurgence, WHO sought to use this interdisciplinary workshop to burnish its human rights credentials, culminating a decade's work in the development of international law for health and employing the rhetorical authority of human rights to further its public health agenda. Following contributions from the Director of the U.N. Division of Human Rights on the evolution of a right to health,[230] two members of the WHO Secretariat presented on this evolving right—one outlining WHO efforts to implement the right to health at the national level[231] and a second discussing WHO coordination in international affairs to realize the right to health and achieve its Health for All strategy.[232] Given renewed consensus on underlying determinants of health within the right to health, there was growing agreement that WHO possessed the constitutional authority to elaborate state obligations for health, with an understanding that global public health practice would benefit from codification of the definition of health in the WHO Constitution. At the pinnacle of this WHO authority for developing international health instruments, WHO manifested its heightened role in leading international normative development for health in the 1978 Declaration of Alma-Ata.

As WHO was participating for the first time in celebrations of the anniversary of the UDHR,[233] as the ICESCR was entering into force and WHO was preparing its first Covenant report,[234] and as the Commission on Human Rights was working with WHO to adopt a draft Convention on the Rights of the Child,[235] WHO and UNICEF came together in September 1978 to hold an international conference in Alma-Ata, USSR that would frame a rights-based approach to achieving WHO's Health for All strategy.[236] To design the contours of this approach, WHO sought to bring together interdisciplinary public health and development actors to address national health systems and determinants of health outside of the control of health ministries. With representatives from 134 state governments, this International

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[229] René Jean Dupuy, *Foreword* to THE RIGHT TO HEALTH AS A HUMAN RIGHT 3 (René Jean Dupuy ed., Sijthoff & Noordhoff 1979).

[230] Theo C. van Boven, *The Right to Health: Paper Submitted by the United Nations Division of Human Rights*, *in* THE RIGHT TO HEALTH AS A HUMAN RIGHT, *supra* note 229, at 54.

[231] Maurice Sédeuilh, *Le Droit à Santé*, *in* THE RIGHT TO HEALTH AS A HUMAN RIGHT, *supra* note 229, at 101.

[232] Claude-Henri Vigne, *Droit à la Santé et Coordination*, *in* THE RIGHT TO HEALTH AS A HUMAN RIGHT, *supra* note 229, at 304.

[233] *Human Rights Day 10 December, 1978: Thirtieth Anniversary*, WORLD HEALTH 16 (1978).

[234] WHO, *Report on the Implementation of Article 12 of the International Covenant on Economic, Social and Cultural RightsReport on the Right to Health in Article 12 ICESCR*, U.N. Doc. E/1980/24 (Feb. 22, 1980).

[235] *See* Question of a Convention on the Rights of a Child, ECOSOC, Comm'n on Human Rights Res. 20 (XXXIV), U.N. Doc. E/1978/34 (Mar. 8, 1978).

[236] Carl Taylor & Richard Jolly, *The Straw Men of Primary Health Care*, 26 SOC. SCI. & MED. 971, 976 (1988).

Conference adopted the Declaration on Primary Health Care[237] (a document that has come to be known as the Declaration of Alma-Ata), through which delegates memorialized their agreement that primary health care was the key to attaining health for all.

The Declaration of Alma-Ata focuses on primary health care, from which it derives national and international obligations to realize "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford."[238] Reaffirming the preambular language of the WHO Constitution, specifically that health "is a fundamental human right," Article I of the Declaration of Alma-Ata proclaimed that "health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." To achieve this intersectoral government obligation for underlying determinants of health, extending language from the WHO Constitution, the Declaration holds that:

> Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.[239]

Outlining policies to realize health as a human right, this declaratory language sought to achieve equity in health resources for primary health care.[240] To attain the goal of "health for all by the year 2000," the Declaration of Alma-Ata sought to rectify inequalities in public health both among and within states, encouraging states to work together to establish a New International Economic Order and to prioritize disadvantaged groups in achieving "equity-oriented targets." Noting the responsibility of governments for health equity, it memorialized global consensus that primary health care—implemented through national health systems and international economic development—was a key to social justice.

In operationalizing this human rights foundation for health equity, the Declaration found that realization of primary health care "requires the action of many other social and economic sectors in addition to the health sector," exceeding the medical paradigm formerly espoused by WHO and comporting with the interdisciplinary public health approach to underlying determinants of health. Under the

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[237] WHO, *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, Sept. 6–12, 1978, , U.N. Doc. A56/27 (1978).

[238] *Id.* § VI.

[239] *Id.* § V.

[240] BRITISH MEDICAL ASSOCIATION, THE MEDICAL PROFESSION AND HUMAN RIGHTS: HANDBOOK FOR A CHANGING AGENDA 317 (2001).

Declaration of Alma-Ata's holistic, intersectoral approach to basic needs, states expanded upon the provisions codified in the ICESCR,[241] laying out specific rights-based governmental obligations for essential aspects of primary health care, including:

> (1) education concerning prevailing health problems and methods of preventing and controlling them;
> (2) promotion of food supplies and proper nutrition;
> (3) adequate supplies of safe water and basic sanitation;
> (4) maternal and child health care, including family planning;
> (5) immunization against major infectious diseases;
> (6) prevention and treatment of locally endemic diseases; and
> (7) the provision of essential medicines.[242]

Thus, despite an acknowledgement of the principle of progressive realization—giving flexibility to national plans and strategies based upon the state's stage of development and other political, social, and technical factors[243]—the Declaration was intended to guide states in their application of the principle of progressive realization, promoting an emphasis on underlying determinants of health rather than individual curative treatments, while creating model policy standards for planning, analysis, and monitoring.[244]

To design these national plans, the Declaration of Alma-Ata highlighted a right of participation in health decision-making.[245] Drawing on human rights theory regarding the interdependence of human rights, the Declaration of Alma-Ata found that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care." The resulting Declaration focused on "participation" in health policy decisions, from which it derived obligations on states to provide "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford."[246] By specifying participatory obligations under this right, the Declaration aimed to promote a reorientation of national health development strategies to incorporate and fund primary health care programs in line with the needs of the nation.

To codify these participatory health needs in national legislation, the Declaration of Alma-Ata resurrected language lost in negotiations on the ICESCR, emphasizing law as a tool for creating sustainable national public health systems:

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[241] Frank P. Grad & Ilise L. Feitshans, *Article 12—Right to Health*, *in* U.S. RATIFICATION OF THE INTERNATIONAL COVENANTS ON HUMAN RIGHTS 206, 206–35 (H. Hannum & D.D. Fischer eds., 1993).

[242] *Declaration of Alma-Ata, supra* note 237, § VII.

[243] WHO, PRIMARY HEALTH CARE: REPORT OF THE INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE 18, 24, 74 (1978) [hereinafter WHO, PRIMARY HEALTH CARE].

[244] Virginia Leary, *Implementation of the International Covenant on Economic, Social and Cultural Rights: Day of General Discussion on the Right to Health*, U.N. Doc. E/C.12/1993/WP.27 (1993).

[245] *Declaration of Alma-Ata*, *supra* note 237, § IV.

[246] *Id.*

> In some countries, legislation will be required to facilitate the development of primary health care and the implementation of its strategy. Thus there might be a need for new legislation or the revision of existing legislation, to permit communities to plan, manage and control primary health care and to allow various types of health workers to perform duties hitherto carried out exclusively by health professionals. On the other hand, there often exists laws which are not applied but which, as they stand, might be used to facilitate the development of primary health care.[247]

While this legislative focus was not as prominent as it was in early drafts of previous international legal standards,[248] this endorsement of legislation as a determinant of health was seen as vital to creating lasting institutions for primary health care in national health policy.[249]

By laying out criteria for national and global health policy in developing primary health care, and declaring these criteria to be human rights—rights that would have priority over other goals—the Declaration of Alma-Ata presented WHO's first unifying framework for advancing public health under the mantle of the right to health.[250] Subsequent to the Declaration, the WHO Executive Board in January 1979 invited WHO member states to use it as the basis for formulating national policies in meeting the goals of "Health for All by the Year 2000."[251] Yet despite WHO's rights-based discourses and leadership leading up to Alma-Ata, its historical weaknesses in the development and implementation of human rights frameworks would contribute to the ultimate failure of WHO's Health for All strategy and the abandonment of the Declaration of Alma-Ata.

III. LEGACIES OF WHO NEGLECT

The 1948 WHO Constitution envisioned an expansive role for human rights protection and promotion in realizing public health, but WHO failed to live up to this role. After showing influential leadership in developing and implementing health rights, WHO abruptly sought to distance itself from international human rights frameworks. While U.N. policy-making bodies routinely discussed human rights coordination in the 1950s and 1960s, often with the active participation of specialized agencies, the WHO Secretariat remained absent throughout this evolution in human rights. Compounded by WHO's reluctance to cooperate with the U.N. in human rights,[252] desire to avoid politicizing its work during the height of the

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247 WHO, PRIMARY HEALTH CARE, *supra* note 243, at 76.

248 Taylor, *supra* note 214, at 42–43.

249 *See* Sev S. Fluss & Frank Gutteridge, *Some Contributions of the World Health Organization to Legislation*, *in* ISSUES IN CONTEMPORARY INTERNATIONAL HEALTH 35 (Thomas A. Lambo & Stacey B. Day eds., 1990).

250 *See* THOMAS H. MACDONALD, HEALTH, HUMAN RIGHTS AND THE UNITED NATIONS: INCONSISTENT AIMS AND INHERENT CONTRADICTIONS? (2008).

251 WHO Executive Board Res. 21, U.N. Doc. EB63/R21 (Jan. 1979).

252 *See* Samson, *supra* note 116.

Cold War,[253] and grounding in the conservative organizational culture of medical professionals,[254] these vicissitudes in institutional leadership for human rights ultimately limited WHO's ability in the 1970s to carry out global health policy under its right-based Health for All strategy. Without established human rights frameworks to guide primary health care, WHO leaders could not bring states to accept their obligations to realize underlying determinants of health. That is, where WHO focused on health as a set of functional problems rather than as a human right, it failed to achieve both, undercutting its own practical health goals by denying them a grounding in the legal frameworks of the right to health.

Despite WHO's efforts to mainstream human rights in its Health for All strategy, WHO was hobbled in these efforts by its inability to engage with the language of law or set standards under international agreements.[255] The early reticence of the WHO Secretariat toward human rights—never developing personnel devoted to human rights or incorporating its Legal Office in any rights-based communications with the U.N.[256]—limited WHO's contributions to human rights institutions, as it repeatedly declared legal rights to be "beyond the competence of the World Health Organization."[257] Even when WHO personnel came to discuss and apply human rights principles in the 1970s, they did so ineffectually, engaging in platitudinous statements unsuited to the development, interpretation, and implementation of international legal standards.[258] WHO's Health for All strategy was conceptualized in human rights terms but with human rights depicted as a general humanitarian imperative rather than a specific legal obligation. Thus, although the Declaration of Alma-Ata framed its programmatic obligations on the basis of a human right to health, it did so without any specific reference to treaty law, a particularly disempowering omission given contemporaneous human rights advocacy based upon the ICESCR's promulgation of a human right to health. Where WHO legal officers saw "no direct link between article 12 [of the ICESCR] . . . and WHO standards,"[259] the WHO Secretariat would see no justification for engaging with national or international law to give meaning to this right for underlying determinants of health. Where WHO had long sought to address health issues through direct action in the absence of legal frameworks,[260] the inherent limitations of this approach became transparent in the failure to achieve rights-based reform through the Declaration of Alma-Ata, with scholars noting in its wake that "inadequate national commitment

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[253] MATTHEW CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 16–22 (1995).

[254] Taylor, *supra* note 214, at 72–74.

[255] Allyn Lise Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301, 338 (1992).

[256] Memorandum from F. Gutteri dge, Dir., Legal Office, WHO, to Milton P. Siegel, Assistant Dir.-Gen., WHO (Oct. 27, 1966) (on file with author).

[257] Letter from P. Dorolle, *supra* note 179.

[258] HENRIK KARL NIELSEN, THE WORLD HEALTH ORGANISATION: IMPLEMENTING THE RIGHT TO HEALTH 48 (1999); Alison Lakin, *The Legal Powers of the World Health Organization*, 3 MED. L. INT'L 23, 32 (1997); Alison Lakin, The World Health Organisation and the Right to Health 140 (2001) (unpublished Ph.D. dissertation, King's College) [hereinafter Lakin dissertation].

[259] Mark E. Battista, An Enforceable Human Right to Health: A New Role for WHO 11 (World Peace Through Law Center 1981) (citing Letter from Alberto Rodriguez, Legal Officer, Pan American Health Org., to Mark E. Battista (Apr. 3, 1981)).

[260] Virginia Leary et. al., *Health Human Rights and International Law*, 82 AM. SOC'Y INT'L L. PROC. 122, 129 (1988).

to the Health for All is at some level a reflection of the ineffectiveness of WHO's strategy of securing national dedication to the right to health."[261] Without regulations to clarify and operationalize this right through legal obligations, subsequent analysts have criticized the Health for All strategy merely as "dependent on goodwill" of national ministries, lamenting that "it is difficult to envisage such generality being an effective advocacy tool or being sufficiently specific to assess health policy and practice."[262] While WHO possessed invaluable technical expertise in public health matters, giving it preeminent legitimacy in developing public health standards and monitoring national health programs, WHO needed to be competent to frame these normative and evaluative processes pursuant to human rights law if it was to bind states to achieve "health for all." Out of this experience, legal advocates came to see the importance of law to WHO's realization of the right to health,[263] with WHO belatedly seeking to use its technical cooperation program to strengthen national capacities for health legislation, to employ consultants to draft enabling legislation for national primary health care systems, and to sponsor conferences to promote the role of legislation as a tool for implementing health policy.[264]

While it would be imprudent to place the blame on WHO itself, as its budget and policies purport to represent the collective expression of its member states,[265] it is clear in this historical context that the WHO Secretariat had dispositive institutional authority to act independently in advancing human rights for health. Moreover, it had a leadership obligation pursuant to its constitutional mandate to direct and coordinate international law[266] and human rights development for the advancement of public health.[267] Where other international organizations sought an expanding role for international law in human rights, WHO sought neither legal frameworks for rights-based development nor advocate mobilization for rights-based implementation. Although WHO sought briefly to cooperate with the Committee on Economic, Social, and Cultural Rights in February 1980 by reporting (as required by Article 18 of the ICESCR) on the rights covered by Article 12 of the ICESCR,[268] this long-delayed effort focused exclusively on global issues of "generic implementation," rather than on country-specific progress, and consequently, WHO's report fell on deaf ears.[269] In the wake of this exclusion as a legitimate actor in human rights implementation, WHO thereafter skirted its continuing ICESCR obligations to monitor national reports on the right to health.[270] With periodic exceptions, WHO has continued to avoid this human rights imperative, denying its health recommendations the moral suasion of legal strictures. This enduring ne-

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[261] Taylor, *supra* note 214, at 42.

[262] Lakin dissertation, *supra* note 258, at 114, 140.

[263] *See* THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY (Hernán L. Fuenzalida-Puelma & Susan Scholle Connor eds., 1989).

[264] *See* Fluss & Gutteridge, *supra* note 249.

[265] Gutteridge, *supra* note 23, at 7–8.

[266] David P. Fidler. *The Future of the World Health Organization: What Role for International Law?*, 31 VAND. J. TRANSNAT'L L. 1079, 1086–89 (1998).

[267] Taylor, *supra* note 214, at 6–14.

[268] *See* WHO, *supra* note 234.

[269] Trubek, *supra* note 156, at 244.

[270] Taylor, *supra* note 214, at 47.

glect has led the right to health to fall from the UDHR's promise of lexical rigidity to its current state of aspirational fluidity, rarely legislated or litigated.[271]

Without consistent WHO support for human rights to underlying determinants of health in the years leading up to the Declaration of Alma-Ata, states could credibly find WHO's Health for All strategy, with a focus on economic redistribution, to be beyond the purview of its organizational mandate.[272] When the situs of global health governance moved from the U.N. system to international economic institutions at the end of the 1970s, there were no international human rights standards in place to challenge these new institutional realities and prevent the collapse of the Health for All strategy.[273] As a result of the failure of the Declaration of Alma-Ata, WHO's leadership in health rights was displaced by the influence of international economic institutions, with WHO's mission for health and human rights dispersed among other U.N. agencies and intergovernmental organizations.[274] Due to this usurpation of health authority by economic institutions, promoting individual responsibility for health, and direct sector lending for medical services, the comprehensive obligations of the Declaration of Alma-Ata suffered from medical reductionism. With international health programs emphasizing "tangible results instead of promoting change,"[275] these economic institutions reduced the breadth of primary health care to Selective Primary Health Care,[276] programmatized under a GOBI (Growth-monitoring, Oral-rehydration, Breast-feeding, and Immunization) approach to international development spending in national health sectors.[277] As selective primary health care then refocused global health policy toward the provision of medicine and health technology, thereby reasserting a reliance on scientific progress in solving medical harms, this medicalization of the right to health was incorporated into health guidelines under the 1981 WHO Global Strategy for Health for All by the Year 2000.[278] Rather than proposing effective primary health care systems to ameliorate underlying determinants of health, the Organization's focus shifted back to "health services systems" to address the provision of medical care,[279] in what was described as a "counter-revolution" to the gains of the Declaration of

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[271] *See* CORE OBLIGATIONS, *supra* note 5.

[272] *See* Karen A. Mingst, *The United States and the World Health Organization*, *in* THE UNITED STATES AND MULTILATERAL INSTITUTIONS: PATTERNS OF CHANGING INSTRUMENTALITY AND INFLUENCE 205 (Margaret P. Karns & Karen A. Mingst eds., 1990); D. Rajagopalan-Vorburger, World Health Organization and the Right to Health: A Legal Analysis of Its Interaction with Other Institutions (2002) (unpublished Ph.D. dissertation, Institut Universitaire de Hautes Études Internationales).

[273] Caroline Thomas & Martin Weber, *The Politics of Global Health Governance: Whatever Happened to "Health for All by the Year 2000"?*, 10 GLOBAL GOVERNANCE 187, 189–91 (2004).

[274] George A. Silver, *International Health Services Need an Interorganizational Policy*, 88 AM. J. PUB. HEALTH 727, 728 (1998).

[275] David A. Tejada de Rivero, *Alma-Ata Revisited*, 8 PERSP. IN HEALTH 1, 4 (2003).

[276] Julia A. Walsh & Kenneth S. Warren, *Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries*, 301 NEW ENG. J. MED. 967, 968 (1979).

[277] Marcus Cueto, *The Origins of Primary Health Care and Selective Primary Health Care*, 94 AM. J. PUB. HEALTH 1864, 1869 (2004).

[278] WHO, WORLD HEALTH GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000 (1981).

[279] *See* Milton I. Roemer, *Analysis of Health Services Systems: A General Approach*, *in* REORIENTING HEALTH SERVICES: APPLICATION OF A SYSTEMS APPROACH 47 (Charles O. Pannenborg et al. eds., 1984); JOHN M. STARRELS, THE WORLD HEALTH ORGANIZATION: RESISTING THIRD WORLD IDEOLOGICAL PRESSURES (1985).

Alma-Ata.[280] In this return to an emphasis on vertical health programming, developing states reduced health expenditures and health inequalities widened.[281] By 1988, WHO conceded the impossibility of its initial primary health care agenda and removed the "by the Year 2000" deadline from its Health for All campaign.[282]

Given the rise of the neoliberal economic paradigm in international development policy, a limited individual right to health—thereafter interpreted predominantly as a right to health care[283]—has confined rights-based advocates to pressing for discrete individual health services to address problems whose solutions require social change through public health systems.[284] With states seeking to further human rights for health in the absence of guidance from WHO, these rights-based advancements would be framed in the language of "patient's rights" to medical care.[285] When WHO again took up the reins of human rights in the late 1980s, this human rights mandate was framed solely in the language of negative rights (e.g., discrimination and stigma) and limited to the unique circumstances of the HIV/AIDS pandemic.[286] Yet it was during this period—when the hegemony of the neoliberal economic paradigm necessitated a return to a Health for All strategy—that WHO's weaknesses in rights-based approaches to health were most painfully felt by those in greatest need.[287] The neoliberal economic paradigm—including policy prescriptions for privatization, deregulation, and decentralization—has led to the dismantling of national health systems and the reorienting of economic development to the detriment of developing states, exacerbating health inequalities within and between countries.[288] In the aftermath of neoliberal economic reforms and the spread of neoliberal ideology, the broad definition of primary health care laid out in the Declaration of Alma-Ata has been replaced by one that focuses on vertical, narrow, curative interventions in the context of national health system retrenchment, reduced health expenditure, and widening health inequities.[289] Rather than oppose this para-

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[280] Kenneth Newell, *Selective Primary Health Care: The Counter Revolution*, 26 SOC. SCI. & MED. 903, 906 (1988).

[281] Abraham Horwitz, *Changing Concepts of Health and Health Services: New Opportunities for Nutrition Promotion*, 17 BULL. PAN AM. HEALTH ORG. 61, 61–63 (1983).

[282] Strengthening Primary Health Care, World Health Assembly Res. 41.34 (May 13, 1988).

[283] Ruth Roemer, *The Right to Health Care*, *in* THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY, *supra* note 263, at 17.

[284] Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101, 117–18 (2005); *See* Maria Stuttaford, *Balancing Collective and Individual Rights to Health and Health Care*, L., SOC. JUST. & GLOBAL DEV. J.2004 (1), *available at* http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/stuttaford/.

[285] *See, e.g.*, WHO Reg'l Office for Eur., *Draft European Declaration on the Rights of Patients*, ICP/HLE 117 (1990) (on file with author).

[286] Global Strategy for the Prevention and Control of AIDS, World Health Assembly Res. 40.26, (May 15, 1987); Jonathan M. Mann, *The World Health Organization's Global Strategy for the Prevention and Control of AIDS*, 147 WEST. J. MED. 732, 734 (1987).

[287] Halfdan Mahler, *Foreword* to MACDONALD, *supra* note 250; Daniel Tarantola, *A Perspective on the History of Health and Human Rights: From the Cold War to the Gold War*, 29 J. PUB. HEALTH POL'Y 42, 45–46 (2008).

[288] Lincoln C. Chen & Giovanni Berlinguer, *Health Equity in a Globalizing World*, *in* CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 34 (Timothy Evans et al. eds., 2001); *see* HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE (Kelley Lee ed., 2003).

[289] A. J. McMichael & R. Beaglehole, *The Changing Global Context of Public Health*, 356 LANCET 495, 497 (2000).

digm under the legal mantle of health rights, "WHO . . . [fell] victim to neoliberal globalization," forced into public-private partnerships for individual health care instead of primary health care for the public's health.[290] Consequently, even WHO's leadership has been left to concede that although "[n]ever have so many had such broad and advanced access to healthcare . . . never have so many been denied access to health."[291] Despite repeated WHO efforts to address disparities in health care,"[m]any developing countries did not . . . enjoy the benefits of improved public health capabilities experienced in the developed world."[292]

Without access to international legal standards, WHO could conveniently be denied a seat at the development table, excluding it from the global socioeconomic institutions most crucial to realizing improvements in underlying determinants of health.[293] Given the historical weaknesses of WHO's rights-based approach in engaging with development discourses and alleviating the harmful ramifications of neoliberal globalization policies through health systems,[294] WHO turned to economic analysis as a means of engaging development discourse and persuading national governments to increase vertical, disease-specific health spending for macroeconomic growth.[295] Health advocates, not accustomed to working with WHO to develop human rights norms, abandoned the pursuit of legal obligations for health and relegated themselves to the national "commitments" of non-obligatory international discourse through the U.N.'s 2000 Millennium Development Goals (MDGs)[296] and UNAIDS and WHO's "3 by 5" program for the distribution of HIV medications.[297] Yet these efforts, much like previous hortatory goals—celebrated in their creation but abandoned in their codification—have failed to achieve programmatic specificity and legal accountability, enabling further drift away from the promise of Health for All.[298]

In the absence of strong historical support from WHO for human rights obligations appropriate to underlying determinants of health, it has fallen to U.N. human rights institutions—the Committee on Economic, Social, and Cultural Rights[299]

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[290] Letter from Alison Katz, Bd. Member, Centre Eur. Tiers Monde, to Margaret Chan, Dir.-Gen., WHO (Jan. 22, 2007), *available at* http://www.phmovement.org/files/alison_letter.pdf.

[291] Joyce Millen, A. Irwin & Jim Yong Kim, *Introduction: What Is Growing? Who Is Dying?*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR 4 (Jim Yong Kim et al. eds., 2000).

[292] DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 12 (1999).

[293] Kelley Lee et al., *Who Should Be Doing What in International Health: A Confusion of Mandates in the United Nations?*, 312 BRIT. MED. J. 302–07 (1996); Benjamin Mason Meier & Ashley Fox, *Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health*, 30 HUM. RTS. Q. 259, 314 (2008).

[294] Michael Kirby, *The Right to Health Fifty Years On: Still Skeptical?,* 4 HEALTH & HUM. RTS. 6, 13 (1999).

[295] WHO COMM'N ON MACROECONOMICS AND HEALTH, MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT 25 (World Health Organization 2001); R. Waitzkin, *Report of the WHO Commission on Macroeconomics and Health: A Summary and Critique*, 361 LANCET 523–36 (2003).

[296] United Nations Millennium Declaration, G.A. Res. 55/2, U.N. Doc. A/RES/55/2 (Sept. 18, 2000), *available at* http://www.un.org/millennium/declaration/ares552e.pdf.

[297] *See* WHO, TREATING 3 MILLION BY 2005: MAKING IT HAPPEN (2004).

[298] S. Litsios, *The Health, Poverty, and Development Merry-Go-Round: The Tribulations of WHO*, *in* UNDERSTANDING THE GLOBAL DIMENSIONS OF HEALTH 15, 15–33 (S. William, A. Gunn, & P. B. Mansourian eds., 2005).

[299] U.N. Committee on Economic, Social, and Cultural Rights [CESCR], 9th Sess., 42d plen.

and subsequently, the U.N. Special Rapporteur on the Right to Health[300]—to do what WHO could not—interpret the right to health in an expansive way that would set legal standards for national public health systems in accordance with the spirit of the Declaration of Alma-Ata.[301] But given weaknesses in underlying determinants of health in evolving legal norms under the right to health, such interpretations required an explicit acknowledgement of the "dynamic definition of the right to health"[302] and an attempt to interpret the right to health commensurate with evolving public health discourses.[303] To the extent that these efforts in normative expansion have faced criticism for exceeding the limits of their legal mandate for norm clarification,[304] constraining the ability of these interpretations to influence national and global health policy, these limitations to the development and implementation of international legal obligations for public health can be traced back over fifty years, when WHO lost its human rights compass and struggled thereafter to find its way back to the right to health.

IV. CONCLUSION

Only by appreciating the rich history of WHO involvement with health rights are we able to recognize the squandered opportunities for global health governance in advancing a rights-based approach to health—and to learn from those lost opportunities. U.N. Secretary-General Kofi Annan's 1997 "Renewing the United Nations: A Programme for Reform"[305]—explicitly mandating a cross-cutting approach to human rights within the U.N. by which specialized agencies are to "mainstream" human rights in all programs, policies and activities—has paved the way for WHO to incorporate human rights into its public health efforts. WHO has only just begun to institutionalize this cross-cutting approach, most prominently through the creation of its Department of Ethics, Trade, Human Rights and Health Law, which has collaborated prominently with organizations, scholars, and advocates at the intersection of health and human rights. After a decade under this new U.N. approach to human rights, however, this WHO human rights office has faced attrition in its budget and prominence, and it remains to be seen whether WHO will adhere to this evolving U.N. mandate or, as has been done in the wake of so many previous admonitions, revert to its institutional isolation and human rights abnegation. As this challenge unfolds, WHO's 2008 World Health Report, "Primary

mtg., at 1-15, U.N. Doc. E/C.12/1993/SR.42 (Nov. 23, 1994) [hereinafter CESCR 1994]; CESCR, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4. (2000) [hereinafter CESCR 2000].

[300] U.N. Economic and Social Council, Comm'n on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt,* U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003).

[301] Lakin dissertation, *supra* note 258, at 131–34.

[302] CESCR 1994, *supra* note 299, ¶ 7.

[303] *See* CESCR 2000, *supra* note 299.

[304] Timothy Goodman, *Is There a Right to Health?*, 30 J. OF MED. AND PHIL. 643, 652–59 (2005); Katherine Gorove, *Shifting Norms in International Health Law*, 98 AM. SOC'Y OF INT'L L. PROC. 18, 20 (2004).

[305] The Secretary-General, *Renewing the United Nations: A Programme for Reform*, *delivered to the General Assembly*, U.N. Doc. A/51/950 (July 14, 1997).

Health Care—Now More Than Ever," notes striking public health inequities within and between countries and calls for a return to the primary health care approach of the Declaration of Alma-Ata.[306] To the extent that it does so under the aegis of a right to health, this new framework for global health policy may serve as reconciliation between WHO and international human rights, laying the legal foundation necessary to create a lasting legacy of health for all.

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[306] WHO, WORLD HEALTH REPORT: PRIMARY HEALTH CARE—NOW MORE THAN EVER 2–23 (2008), *available at* http://www.who.int/whr/2008/whr08_en.pdf.