

The Highest Attainable Standard:

**The World Health Organization, Global Health Governance, and the Contentious
Politics of Human Rights**

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ABSTRACT

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The human right to health—proclaimed seminally in the 1948 Universal Declaration of Human Rights (UDHR) and codified in the 1966 International Covenant of Economic, Social and Cultural Rights (ICESCR) as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”—has become a cornerstone of global health governance. Heralded as a normative framework for international public health, the right to health is seen as foundational to the contemporary policies and programs of the World Health Organization (WHO).

It was not always so.

This dissertation traces the political history leading up to WHO’s invocation of human rights for the public’s health. With both the UDHR and WHO coming into existence in 1948, there was great initial promise that these two institutions would complement each other, with WHO upholding human rights in all its activities. In spite of this promise and early WHO efforts to advance a human rights basis for its work, WHO intentionally neglected the right to health during crucial years of its evolution, with the WHO Secretariat renouncing its authoritative role in human rights policy to pursue medical care programming. Through legal analysis and historical narrative, this research examines the causes and effects of WHO’s early contributions to and subsequent abandonment of the evolution of health rights.

Where WHO neglected human rights—out of political expediency, legal incapacity, and medical supremacy—it did so to its peril. After twenty-five years shunning the development of the right to health, WHO came to see these legal principles as a political foundation upon which to frame its “Health For All” strategy under the 1978 Declaration of Alma-Ata. But it was too late. This dissertation concludes that WHO’s constrained role in developing and implementing international human rights for health set into motion a course for the right to health that would prove fatal to the goals of primary health care laid out in the Declaration of Alma-Ata.

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As this analysis developed, the preliminary ideas that grew into this dissertation arose over the course of several articles at the intersection of health and human rights, each of which benefited from co-authors, collaborators, and reviewers. Where these inchoate analyses began in a naïve attempt at sole-authorship, they benefited substantially through insightful collaborations with rising and senior scholars, many of whose insights are reflected throughout this dissertation. While it is likely that I have missed many instrumental thinkers in this drawn out process, I draw attention to the following for their contributions to this interdisciplinary adventure: Donna Shelley, James G. Hodge, Jr., Ashley M. Fox, Jocelyn E. Getgen, Sara A. Lulo, Annalijn Conklin, Reilly Anne Dempsey, Yayoi Shionoiri, and Eva Kaplan.

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While many have contributed to this work, any remaining errors lie with me alone.

for YJS

She wasn't there when this began, but she'll be here until the end...

Preface

Health is a fundamental human right, without which no other rights would be possible. Yet it is difficult to parse international legal discourse to uncover legal obligations on state governments to realize this indispensable right. Where once academics shunned scholarship on the right to health, as with other positive rights, the end of the Cold War and advent of economic globalization has brought with it new interest in studies at the intersection of health and human rights. This “health and human rights movement”—spanning legal and public health scholarship throughout the last fifteen years—has contributed a long-sought framework for promoting those human rights beneficial to health. But with these scholars and activists making the reflexive argument that “health is a human right,” the health and human rights movement, while not lacking for advocates, lacks a normative foundation in international legal history. Despite a burgeoning stream of analysis on the scope and content of the right to health, there has been little reexamination of the historical underpinnings of this right.

Since its inception in international law—in both its vague enunciation in the 1948 Universal Declaration of Human Rights and its concretized obligations in the 1966 International Covenant on Economic, Social and Cultural Rights—the right to health has acquired so many, often incongruous, meanings that it is limited as a tool for codifying a government’s discreet health obligations. These ambiguities have stymied efforts to provide guidance as to the specific scope of states’ obligations in implementing the right to health. Without an understanding of the legal history of the right to health, it is not possible to understand the institutions, actors, and processes that will be responsible for

the future evolution of this right. To understand how the right to health has evolved is to know where it is going and how it can get there.

In framing this study, it must be noted *in principio* that the right to health does not guarantee a particular standard of health. Health failures can often be attributed to genetic predisposition, risky behavior, and unfortunate events, but because such health factors are outside of the control of the state and thus beyond the obligations of human rights, it is oft repeated in discussion of the right to health that this right does not provide for a right “to be healthy.” As such, a right to health exists only to the extent that it can be achieved by the positive action of the state. Rather than being inherent in all peoples, a right to health can only be realized if a state implements the right in such a way as to realize healthier conditions. Thus, a right to health—at its minimum and at its maximum—exists only by the methods of disease prevention and health promotion that the state employs to achieve public health goals. If there is to be any right at all, it must be a right subject to evolution in the frameworks of state health policy – i.e., by the changing health threats, theories, and technologies that frame state implementation of public health programs.

I set out to study how states came together in drafting an evolving right to health—seeking to understand the historical underpinnings of the health and human rights movement—but I found a far more instructive story in the role played by the World Health Organization (WHO) in these various iterations of human rights for health. This was a surprise. Like others who have considered the evolution of the health and human rights movement, WHO’s longstanding failure to develop a human rights program led me to the erroneous assumption that it had never played any role in the development

of the right to health. When it became clear that there was an untold history of institutional influence in health rights to rival the history of ideas of the right to health, I worked with my dissertation committee to shift the focus of this dissertation to that of its present incarnation.

While this analysis remains guided by the original methods presented in the dissertation proposal, this final research focuses more narrowly on the role of WHO, a institutional role that has not previously been analyzed in historical studies on human rights. As the United Nations' (UN's) principal specialized agency with purview over the conditions necessary for health, WHO possesses a unique institutional responsibility to implement the right to health through its directing and coordinating authority in international health. Given this revised focus on WHO, I hope that this current study will prove beneficial to those who seek to understand WHO's history, the interactions of international organizations for health cooperation, the role of the UN and other international actors in the development of health rights, and the evolution of the human right to health. The present historical analysis finds that the development of a human right to health in international law is a product of post-War discourses on the role of both health and human rights. By examining these temporally-situated discourses, it is possible to glean insights into the historical meaning of the right to health and the role of international institutions in developing and implementing that right, giving scholars a reference point for understanding how the right to health has evolved since its inception and the grounds upon which it can progress into the future.

Introduction

This dissertation analyzes the discourses that have led to the evolution of legal norms encompassing the human right to health and proposes a framework that can guide the future progression of health rights in responding to current public health challenges.

Despite a burgeoning stream of analysis on the scope and content of the right to health, there has been little reexamination of the foundations of this right, particularly as compared with the rich historical analyses of other human rights. While others have laid out the course of international negotiations in drafting the right to health, no scholar has attempted to uncover the underlying public health discourses that led to the development and evolution of this right. This lack of debate concerning the historical construction of health rights, a discussion no international body has addressed in any detail, has limited efforts to provide guidance as to the specific scope of states' obligations under the right to health and left states with little appreciation of the reasoning upon which they are to accept obligations to provide governmental interventions that were not considered at the time of the right to health's original drafting and promulgation. To inform this debate in a way that will give credence to state obligations to respect, protect, and fulfill the right to health, it is necessary that scholars, policymakers, and advocates appreciate the health discourses and reasoning underlying evolving understandings of 'health' and the scope of the human rights that upholds it. The World Health Organization (WHO), with a constitutional mandate to realize the right to health and a rich history of involvement in the right's evolving legal iterations, provides an ideal case study by which to assess the political dynamics present in the development and implementation of international legal obligations in support of a human right to health.

Researching the history of WHO's political, legal, and medical discourses underlying changing conceptions of a human right to health, this study examines how norms for health rights have developed in international law, analyzing the grounds upon which health rights have evolved in international law since the end of the Second World War and upon which they can progress into the future. In doing so, this dissertation investigates the international relations history that led to the codification of a right to health in an evolving series of international legal documents, seeking to chronicle the underlying normative discourses within WHO that led the translation of public health discourse into the legal language of the right to health. This research finds that WHO faced various limitations in translating public health discourse into human rights law, analyzing the mediating political, legal, and medical factors that have vitiated WHO's efforts to develop and implement health rights. Given these WHO limitations, while the right to health can be shown to have evolved in international legal discourse, such an evolution of the right to health—intrinsically bound by the current human rights framework—cannot address underlying determinants of health through public health systems, a necessary public health imperative in combating the insalubrious effects of global economic policy.

The World Health Organization, Human Rights, and the Failure to Achieve Health for All

Human rights are heralded as a modern guide for public health, a vision of all that public health scholars and practitioners shall uphold in their work. Cited by health advocates throughout the world, the human right to health—proclaimed seminally in article 25 of the Universal Declaration of Human Rights (UDHR) and codified in article

12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR) as the “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”—has become a cornerstone of global health governance. This latter-day *sine qua non* for public health policy, the right to health is seen as foundational to the contemporary policy discourse and programmatic interventions of WHO.¹

It was not always so.

This dissertation study strives to trace the underlying political history leading up to WHO’s invocation of human rights for the public’s health. With both WHO and the UDHR 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 (UN)—serving to support human rights in all its activities. In spite of this promise and early WHO support for advancing a human rights basis for its public health work, WHO intentionally neglected human rights discourse during crucial years in the development of the right to health, projecting itself as a technical organization above “legal rights.”

Where the WHO neglected human rights—out of political expediency, legal incapacity, and medical supremacy—it did so to its peril. After twenty years shunning rights discourse, public health actors came to see these human rights principles as a moral foundation upon which to frame WHO’s “Health For All” strategy under the Declaration of Alma Ata. But it was too late. WHO’s diminished role in shaping the evolution of international human rights law—specifically its actions in the normative development

¹ UN Office of the High Commissioner for Human Rights, Fact Sheet No. 31, The Right to Health, June 2008. No. 31. Online. UNHCR Refworld, available at: <http://www.unhcr.org/refworld/docid/48625a742.html>.

and programmatic implementation of the right to health 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.

Universal Declaration of Human Rights (1948)	International Covenant on Economic, Social and Cultural Rights (1966)	Declaration of Alma Ata (1978)
<p>Article 25</p> <p>(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.</p>	<p>Article 12</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> (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. 	<p>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.</p> <p>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.</p>

This study chronicles the evolution of human rights language for health, focusing on WHO's role in developing and implementing these legal obligations. Starting from a comprehensive legal analysis of the treaty language and *travaux préparatoire* (official treaty preparatory documents) of the human right to health, this research then employs archival research and discourse analysis to examine the UN and WHO communications that sought to develop and implement this right. Through such historical narrative, this research traces 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 and *travaux préparatoire* of the right to health, no previous study has analyzed the underlying organizational discourses that provided the foundation for international treaty negotiations.² For example, Brigit Toebes—whose text, “The Right to Health as a Human Right in International Law,” remains a leading scholarly exposition of the right to health—notes that “[i]n the absence of a record of the reasons of the drafters” of the right to health, the reasons underlying the language of the right to health “remains largely a matter of guesswork.”³ Only through discourse analysis of these institutional communications does it become possible to understand the competing discourses that culminated in the international legal norms of the right to health, highlighting the processes of translating public health discourses into legal norms through human rights development and the successes and failures of implementing those norms to achieve state obligations to realize health for all.

I. Background – Foundation of the World Health Organization, Human Rights Frameworks, and International Systems of Coordination in Health and Human Rights

The codification of a right to health in international law begins, as with all contemporary human rights, in the context of the Second World War. The failure of the League of Nations to prevent rapidly escalating Nazi atrocities through its Minority

² Thomas C, Weber M. The politics of global health governance: Whatever happened to “health for all by the year 2000”? *Global Governance*. 2004;10(2).

³ Toebes BCA. *The Right to Health as a Human Right in International Law*. Antwerp: Intersentia; 1999: 32.

Treaties System gave strength to a growing call for the creation of a new system to protect individual freedom from the tyranny of the state. Heeding this call on January 6, 1941, U.S. President Franklin Delano Roosevelt announced to the world 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.⁴ It is the final of these “Four Freedoms,” freedom from want, that heralded 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 “a necessitous man is not a free man.”⁵ In this wartime context, the “Four Freedoms” speech was initially derided as American propaganda but quickly deepened its impact as it came to form the ideological basis of the alliance between the Allied Powers.⁶

Rising out of the cauldron of war and drawing on working class struggles of the late nineteenth and early twentieth centuries, this freedom from want became enshrined within the lexicon of social and economic rights, seeking state obligations that would serve to prevent deprivations as had taken place during the Depression and War that followed.⁷ Elaborated at the United Nations Conference on Food and Agriculture in May

⁴ Congressional Record. 1941;87:44, 46-47. In Rosenman SI (Ed.). *The Public Papers and Addresses of Franklin D. Roosevelt: 1940. 1941.* 672.

⁵ President Franklin Roosevelt’s Message on the State of the Union, Jan. 11, 1944. *Congressional Record.* 1944;90:55, 57.

⁶ Joint Declaration of the President and the Prime Minister, U.S.-UK, Aug. 14, 1941. *AJIL Supp.* 1941;35:191.

⁷ Chapman A, Russell S. *Core Obligations: Building a Framework for Economic, Social, and Cultural Rights.* New York, NY: Intersentia; 2002.

1943,⁸ this freedom from want would take form in the development of human rights grounded in international law.⁹ Rather than simply appealing to informal notions of religious principle or morality, these human rights were thought to provide a formal legal basis for assessing and adjudicating principles of justice and natural law. With the Allied States meeting in Dumbarton Oaks from August to October 1944 to initiate post-war planning, the protection of human rights would develop out of proposals for a new international organization to replace the League of Nations:

With a view to the creation of conditions of stability and well being which are necessary for peaceful and friendly relations among nations, the Organization should facilitate solutions of international economic, social and other humanitarian problems and *promote respect for human rights and fundamental freedoms.*¹⁰

This proposed organization to promote respect for human rights would soon become the UN.

⁸ Declaration of the United Nations Conference on Food and Agriculture. Hot Springs. May 1943. Reprinted in United Nations Conference on Food and Agriculture: Text of the Final Act Source. *American Journal of International Law.* 1943;37(4)Supp.:159-192.

⁹ Donnelly J. *Universal Human Rights in Theory and Practice.* 2d ed. Ithaca, NY: Cornell University Press; 2003.

¹⁰ United States Department of State. *The United Nations, Dumbarton Oaks Proposal for a General International Organization.* Department of State Publication 2297. Washington, DC: US Government Printing Office. 1944.

A. Charter of the United Nations

The Charter of the United Nations (UN Charter), signed on June 26, 1945, would be the first international treaty to recognize the concept of human rights.¹¹⁻¹² While not enumerated, human rights became one of the four principal purposes of the nascent world body,¹³ elaborated to require states “to take joint and separate action in co-operation with the Organization [UN].”¹⁴ Operating through its Economic and Social Council (ECOSOC), the UN would seek to “make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all.”¹⁵

In drafting the UN Charter, however, states did not initially mention health, either as a goal of the organization or as a human right. In fact, the original October 1944 Dumbarton Oaks proposals, recognizing the importance of human rights to the organization of a post-War world, exclude any mention of health.¹⁶ But for the late efforts of the Brazilian and Chinese delegations to the 1945 San Francisco Conference on International Organization¹⁷—jointly proposing the word “health” as a matter of

¹¹ Stettinius ER. Human rights in the United Nations Charter. *Annals of the American Academy of Political and Social Science*. 1946;243:1-3.

¹² Brunet R. *La Garantie Internationale des Droits de l'Homme d'après la Charte de San Francisco*. Geneva: Grasset. 1947.

¹³ United Nations Charter. 26 June 1945, Preamble.

¹⁴ *Id.* art. 56.

¹⁵ *Id.* art. 62(2).

¹⁶ Health and the nations. *Lancet*. 1945;Aug. 11:177.

¹⁷ Sze S. WHO: From small beginnings. *WHO Forum*. 1988;9:29-34.

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)¹⁸—health would have received no mention in the creation of the UN.¹⁹

UN Charter

Article 13

1. The General Assembly shall initiate studies and make recommendations for the purpose of...b. promoting international cooperation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 55

With a view to the creation of conditions of stability and wellbeing which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote...

- b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
- c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 57

1. The various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and related fields, shall be brought into relationship with the United Nations...
2. Such agencies thus brought into relationship with the United Nations are hereinafter referred to as specialized agencies.

Notwithstanding this invocation of international health in the UN Charter, with ECOSOC proposing an International Health Conference in the following months to establish WHO as a specialized agency of the UN, it would fall to subsequent international negotiations to codify a distinct human right to health in international law.

B. Constitution of the World Health Organization

In doing so, the rapid drafting and adoption of the Constitution of the World Health Organization (WHO Constitution) would make it the first international treaty to

¹⁸ Economic and Social Council. UN Doc. E/9/Rev.1. 15 Feb. 1946.

¹⁹ Summary of actions related to public health during United Nations conference in San Francisco. *Am J Pub Health*. 1945;35:1106-07.

find a unique human right to health, forming the inspirational backdrop for the development of the UDHR's human rights language on health.²⁰ Preparing for the WHO Constitution, the US Public Health Service and Department of State worked with an advisory group of public health scholars to prepare an October 1945 draft constitution, which (along with drafts from the British, French, and Yugoslav delegates) would form the basis of ECOSOC's March-April 1946 Technical Preparatory Committee in Paris, which in turn would develop the thematic outline for the UN's June-July 1946 International Health Conference in New York.²¹ During this five-week International Health Conference, state delegates adopted the proposed WHO Constitution pursuant to articles 55 and 57 of the UN Charter—thereby establishing an Interim Commission of eighteen members to subsume within WHO all of the responsibilities of the Health Organization of the League of Nations, the *Office International d'Hygiène Publique* (OIHP), and the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA).²²⁻²³ To achieve these ends under structures similar to those of the League of Nations and other specialized agencies of the UN, the International Health Conference established three organs through which to implement the goals of the new organization: The World Health Assembly, the legislative policy-making body of WHO,

²⁰ Verdoodt A. *Naissance et Signification de la Déclaration Universelle des Droits de l'Homme*. Louvain, Belgium: Nauwelaerts; 1964.

²¹ Doull JA. Nations united for health. In Simmons JS. (Ed.) *Public Health in the World Today*. Cambridge, Mass.: Harvard University Press. 1949; 317-332.

²² Sawyer WA. Achievements of UNRRA as an international health organization. *Am J Pub Health*. 1947;37(1):41-58.

²³ World Health Organization. *The First Ten Years of the World Health Organization*. Geneva: World Health Organization. 1958.

made up of representatives from each member state; the Executive Board, an executive program-developing subset of the members of the World Health Assembly; and, the Secretariat, carrying out the decisions of the aforementioned organs through the elected Director-General and appointed staff of WHO.

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. Recognizing a pressing post-War imperative to facilitate international cooperation through autonomous global health governance and cooperation among UN specialized agencies for underlying determinants of health,²⁴⁻²⁵ WHO's first stated constitutional function would be “to act as the directing and coordinating authority on international health work.” Whereas previous international health organizations would exist solely to prevent the spread of disease from crossing national boundaries, WHO would extend the preventive medicine efforts of the Rockefeller Foundation’s International Health Program and the League of Nations’ latter years, providing the WHO Secretariat with functional authority to create “necessary action”²⁶ over all manner of disease prevention and health promotion, including, *inter alia*, the realization of underlying determinants of health through policy leadership and technical assistance:

- “to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions, and other aspects of environmental hygiene”

²⁴ Sze S. Today’s global frontiers in public health. *Am J Public Health*. 1945; 35: 96-99.

²⁵ Secretary-General’s Message to the 2nd Session of the Interim Commission of the WHO. Geneva, Switzerland. 6 Nov. 1946.

²⁶ *Constitution of the World Health Organization*. July 22, 1946. art. 2(v).

- “to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment”
- “to study and report on . . . administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security.”

Working with states to meet these expansive functions for medical care and underlying determinants of health through public health systems, WHO’s constitutional framework would pierce the veil of national sovereignty to address the individual’s human right to health,²⁷ employing the preamble of the WHO Constitution to introduce the human rights principles that would frame WHO’s programmatic mission for global health governance.²⁸⁻²⁹

²⁷ Proceedings and final acts of the International Health Conference. *WHO Official Records*. 1946;2:11th Plenary Meeting. 67.

²⁸ Doull JA. Nations united for health. In. 317-332. Simmons JS. Ed. *Public Health in the World Today*. Cambridge, Mass.: Harvard University Press. 1949.

²⁹ Ascher CS. Problems in the World Health Organization’s Program. *International Organization*. 1952;6(1):27-50.

In establishing the contours of a human right to health under the WHO Constitution, a document far more substantively expansive than those of its institutional predecessors,³⁰⁻³¹ the Preamble (in language borne of the eighteenth century's Age of Reason³²) 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."³³ To enable this positive vision of health, expanding the mandate of

Constitution of the World Health Organization

Preamble

The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Accepting these principles, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency of the United Nations.

³⁰ Masters, RD. *International Organization in the Field of Public Health*. Carnegie Endowment: Washington, DC; 1947.

³¹ Gutteridge F. The World Health Organization: Its scope and achievements. *Temple Law Quarterly*. 1963;37(1):1-14.

³² Grad FP. The preamble of the Constitution of the World Health Organization. *Bulletin of the World Health Organization*. 2002;80(12):981-982.

³³ *Constitution of the World Health Organization*. July 22, 1946. Preamble.

international public health far beyond the “absence of disease” originally envisioned by early International Sanitary Conventions, 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.”³⁴ In meeting this expansive, positive definition of health through national public health systems’ focus on ‘social medicine’ to address underlying determinants of health,³⁵⁻³⁶ states parties to WHO would declare 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*.³⁷ Among state delegations, it was held that these health and social measures, developed through national and international legislation, would serve to create “a common front against poverty and disease.”³⁸ With state representatives believing that they were creating the conceptual framework for an entirely new human right, this right to health would be developed in international law and implemented through legal implementation, with WHO wielding authority to create normative standards for this nascent right through the promulgation of international health regulations binding on all states, the drafting of

³⁴ Stampar A. Suggestions relating to the Constitution of an International Health Organization. *WHO Official Records*. 1949;Annex 9:1.

³⁵ Ryle JA. Changing Disciplines: Lectures on the History Method and Motives of Social Pathology. London: Oxford University Press;1948.

³⁶ Sand R. *The Advance to Social Medicine*. London: Staples Press;1952.

³⁷ *Constitution of the World Health Organization*. July 22, 1946. Preamble (emphasis added).

³⁸ Doull JA. Nations united for health. In Simmons JS. (Ed.) *Public Health in the World Today*. Cambridge, Mass.: Harvard University Press;1949:317-332:329.

international conventions for state ratification, and the harmonization of domestic legislation to realize health rights.³⁹ As compared with the Preamble of the UN Charter, which speaks in aspirational terms and introduces the text to follow, this preambular language of the WHO Constitution would codify far-reaching human rights norms commensurate with contemporary public health discourse⁴⁰ – creating what would be referred to as a “Magna Carta of health,”⁴¹ “represent[ing] the broadest and most liberal concept of international responsibility for health ever officially promulgated,”⁴² and encompassing the aspirations of WHO’s mandate following the ravages of the Second World War.⁴³

C. Universal Declaration of Human Rights

Drawing on these negotiations for the WHO Constitution, the UN proclaimed its UDHR on December 10, 1948, establishing through it “a common standard of achievement for all peoples and all nations.”⁴⁴ Defining a collective set of interrelated

³⁹ Leive DM. *International Regulatory Regimes: Case Studies in Health, Meteorology, and Food*. Lexington, Mass: Lexington Books;1976.

⁴⁰ Sigerist HE. *Medicine and Human Welfare*. New Haven: Yale University Press;1941.

⁴¹ Parran T. Remarks at concluding meeting of International Health Conference. UN Doc. E/H/VP/18. 2. Reprinted in Parran T. Chapter for world health. *Public Health Reports*. 1946;61:1265-1268.

⁴² Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43, 30.

⁴³ Bok S. Rethinking the WHO definition of health. *Harvard Center for Population and Development Studies, Working Paper Series*. 2004;17(7):1-14.

⁴⁴ *Universal Declaration of Human Rights*. G.A. Res. 217A(III), U.N. GAOR, 3d Sess., at 71, U.N. Doc. A/810; 1948: art. 7.

social welfare rights for all peoples, the nascent United Nations 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.⁴⁵

In preparing this right to a standard of living adequate for health, derived from drafts of the American Law Institute,⁴⁶⁻⁴⁷ there was widespread international agreement that this human right to health included both the fulfillment of medical care and the realization of underlying determinants of health – including within this right public health obligations for food safety and nutrition, sanitary housing, disease prevention, and comprehensive social security.⁴⁸⁻⁵⁰ Framing international negotiations on the UDHR for the First Session of ECOSOC's Commission on Human Rights, the UN Secretariat

⁴⁵ Universal Declaration of Human Rights. 1948; article 25(1) (emphasis added).

⁴⁶ Committee of Advisers on Essential Human Rights, American Law Institute. Statement of essential human rights. *Annals of the American Academy of Political and Social Science*. 1946 (Jan.);243:18-26.

⁴⁷ Humphrey JP. *Human Rights and the United Nations: A Great Adventure*. Dobbs Ferry, NY: Transnational Publishers. 1984.

⁴⁸ Jenks CW. The five economic and social rights. *Annals of the American Academy of Political and Social Science*. 1946 (Jan.);243:40-46.

⁴⁹ United Nations. *These Rights and Freedoms*. UN Department of Public Information. 1950.

⁵⁰ Eide A. Article 25. In *The Universal Declaration of Human Rights: A Commentary*. Eide A, Alfredsson G, Melander G, Rehof LA, Rosas A. Scandinavian University Press: Oslo, Norway. 1993.

Draft contained multiple suggested provisions relevant to both medical care and underlying determinants of health:

- Article 35 – Everyone has the right to medical care. The State shall promote public health and safety.
- Article 39 – Everyone has the right to such equitable share of the national income as the need for his work and the increment it makes to the common welfare may justify.
- Article 40 – Everyone has the right to such help as may be necessary to make it possible for him to support his family.
- Article 41 – Everyone has the right to social security. The State shall maintain effective arrangements for the prevention of unemployment and for insurance against the risks of unemployment, accident, disability, sickness, old age, and other involuntary or undeserved loss of livelihood.
- Article 42 – Everyone has the right to good food and housing and to live in surroundings that are pleasant and healthy.⁵¹

In an effort toward brevity in the UDHR,⁵² the UN Secretariat Draft collected these health rights into two separate articles:

Everyone has the right to medical care. The State shall promote public health and safety.

⁵¹ Draft Outline of the International Bill of Rights, prepared by the Division of Human Rights. UN ESCOR. E/CN.4/AC.1/3/Add.1, at 285-189. 4 June 1947.

⁵² Morsink J. *The Universal Declaration of Human Rights: Origins, Drafting, and Intent.* University of Pennsylvania Press. Philadelphia. 1999.

Everyone has the right to good food and housing and to live in surroundings that are pleasant and healthy.⁵³

In considering this draft language, many state delegates on the Drafting Committee were determined to include in the UDHR a recognition of the importance of ‘public health,’ with preliminary emphasis on draft article 35’s statement that “the state shall promote public health and safety.” While this appeared a collective responsibility rather than an individual right,⁵⁴ this state obligation for the public’s health, paired with a right to medical care, made comprehensive the public health understanding that state obligations for health would entail both individual health services and national health systems, the latter to include social measures for the public’s health.

Thus, out of the First Session of the Commission on Human Rights’ Drafting Committee, this right was converted to:

Everyone, without distinction as to economic or social conditions, has a right to the highest attainable standard of health.

The Responsibility of the State and community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures.⁵⁵

This expansive rights-based vision of public health systems at the national and community level was in accordance with (1) the expansion of post-War European

⁵³ Secretariat Draft Outline to Economic and Scoial Council. Commission on Human Rights Drafting Committee. E/CN.4/21. Annex A. 1 July 1947.

⁵⁴ Morsink J. *The Universal Declaration of Human Rights: Origins, Drafting, and Intent.* University of Pennsylvania Press. Philadelphia; 1999.

⁵⁵ Suggestions of the Drafting Committee of the Economic and Scoial Council Commission on Human Rights. E/CN.4/21. Annex F. 1 July 1947.

welfare policy, founded on the notion that “social security cannot be fully developed unless health is cared for along comprehensive lines;”⁵⁶ (2) the early development of health 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;”⁵⁷⁻⁵⁸ 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.”⁵⁹ As a result of this developing consensus on the importance of underlying determinants of health, framed under the broad umbrella of ‘social security,’ the Second Session of the Commission on Human Rights amended the right to encompass the following language:

1. Everyone has the right to social security. The State has a duty to maintain or ensure the maintenance of comprehensive measures for the security of the individual against the consequences of unemployment, disability, old age and all other loss of livelihood for reasons beyond his control.

⁵⁶ Inter-Departmental Commission on Social Insurance and Allied Services. *Social Insurance and Allied Services: Report by Sir William Beveridge*; 1942.

⁵⁷ American Declaration of the Rights and Duties of Man. OAS Resolution XXX. Art. XI. OEA/Ser.L/V/II, 23 doc., 21 rev. 6. 1948.

⁵⁸ Fuenzalida-Puelma HL, Connor SS. *The Right to Health in the Americas: A Comparative Constitutional Study*. Pan American Health Organization: Washington; 1989.

⁵⁹ Konstitutsiia SSSR. Art. 120. 1936. Reprinted in Georgadze M., ed. *USSR, Sixty Years of the Union 1922-1982 : A Collection of Legislative Acts and Other Documents*. 1982; 229-259.

2. Motherhood shall be granted special care and assistance. Children are similarly entitled to special care and assistance.⁶⁰

To delineate the aspects of social security crucial to the realization of human rights, the Third Session of the Commission on Human Rights reintroduced health and medicine to this draft article:

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

2. Mother and child have the right to special care and assistance.⁶¹

When the debate moved to the General Assembly, there was little explicit discussion of the health issues in this draft article,⁶² with the nine proposed amendments focusing instead on defining the comprehensive right to social security. While a desire for brevity led many state representatives to insist on the exclusion of article 25's listing of the component rights essential to health and well-being, the Soviet Union's insistence on a circumscribed right to medical care forced the full elaboration of rights to underlying determinants of health.

⁶⁰ ECOSOC. Report of the Second Session of the Commission on Human Rights. E/600. 1947.

⁶¹ ECOSOC. Report of the Third Session of the Commission on Human Rights. E/800. 1948.

⁶² United Nations. *These Rights and Freedoms*. New York: UN Department of Public Information. 1950.

With only minor final amendments, the General Assembly unanimously (40-0, 2 abstentions) adopted the following text of article 25 of the UDHR:

- (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Buttressed by article 27's right "to share in scientific advancement and in its benefits," there was widespread international agreement that a human right to health included both the fulfillment of necessary medical technologies and the realization of underlying determinants of health – explicitly including food, clothing, housing, and social services as part of this holistic encapsulation of health determinants.

D. International Cooperation for Health Rights

In implementing these health rights through the UN and its specialized agencies—then numbering ten UN 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 health rights. For health and human rights, cooperation would be institutionalized through ECOSOC, to which the UN delegated authority in the UN Charter for coordination of all UN activities in the economic and social fields. Under this authority, ECOSOC—then consisting of eighteen

member states, including five permanent members—was empowered under article 62 of the UN Charter to, among other things, (1) create studies, reports, and recommendations with respect to international economic, social, cultural, educational, health, and related matters; (2) draft human rights conventions for recommendation to the General Assembly; and (3) convene conferences to further international discourse.⁶³

UN Charter, Article 62

1. The Economic and Social Council may make or initiate studies and reports with respect to international economic, social, cultural, educational, health, and related matters and may 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.
2. It may make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all.
3. It may prepare draft conventions for submission to the General Assembly, with respect to matters falling within its competence.
4. It may call, in accordance with the rules prescribed by the United Nations, international conferences on matters falling within its competence.

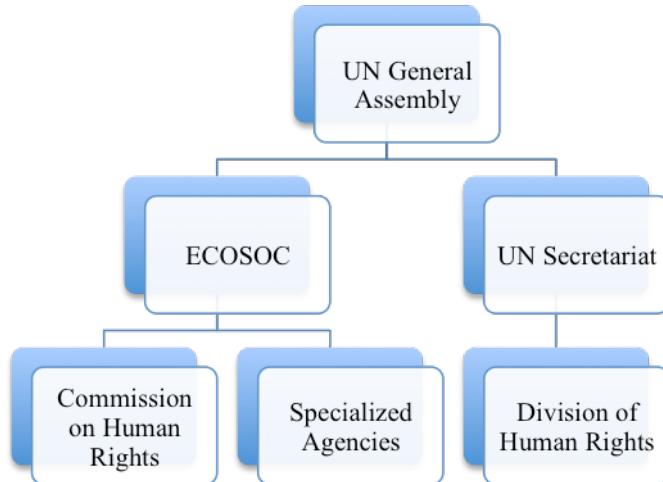
Operating through its commissions and sub-commissions, the ECOSOC Commission on Human Rights—entrusted to “make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all”⁶⁴—bore responsibility for translating the hortatory rights of the UDHR into international treaties that would be legally binding on states parties.⁶⁵ This Commission on Human Rights would bring together states and international organizations in drafting the international legal language and developing the implementation mechanisms for human rights norms. In coordinating this information from states and international organizations and

⁶³ UN Charter. Art. 62(1). 1945.

⁶⁴ ECOSOC Res. 1/5. 16 Feb. 1946.

⁶⁵ Green JF. *The United Nations and Human Rights*. Washington: Brookings Institution; 1956.

completing independent studies of human rights, the Commission on Human Rights drew on the bureaucratic efforts of the UN Secretariat's Division of Human Rights, which would work across the UN and its specialized agencies to develop studies and information needed in all UN human rights efforts.



Furthering inter-agency collaborations, the 1949 establishment of the UN Secretary-General's Administrative Committee on Co-ordination (arising out of the 1946 UN Interim Commission and composed of the UN Secretary-General and directors-general of the various specialized agencies) would act to “ensure the fullest and most effective implementation” of UN mandates by institutionalizing cooperation across the UN’s specialized agencies – primarily including WHO, the 1919 International Labor Organization (ILO), the 1945 Food and Agriculture Organization (FAO), and the 1946 United Nations Educational, Scientific and Cultural Organization (UNESCO). Supplemented by agreements between these specialized agencies—on issues of joint programmes, exchanges of information, and participation in technical meetings—this Administrative Committee on Co-ordination ensured that UN agencies had a forum to coordinate across agencies where their interests overlapped. For coordination of

specialized bodies outside of this system (e.g., the 1946 United Nations Children's Fund (UNICEF), 1944 International Bank for Reconstruction and Development (World Bank), and 1863 International Committee of the Red Cross (ICRC)), relationships were formalized through consultations and ad hoc agreements for specific programs.

Given this rising imperative for the post-War advancement of human rights, national governments, intergovernmental organizations, and nongovernmental organizations would all come to work within the UN system in redefining human rights for health. In doing so, national governments had various opportunities to send memoranda to the Division of Human Rights, Commission on Human Rights, and UN Secretary-General to influence draft language of various international documents, which in most cases were finalized by state delegates themselves. Intergovernmental regional organizations outside of the UN 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—drafted their own distinct human rights obligations but do so in an explicit way that would complement, rather than contradict, UN efforts.⁶⁶ Finally, nongovernmental organizations—those officially recognized for consultations under article 71 of both the UN Charter and WHO Constitution and those simply sending organizational resolutions and memoranda to the UN and WHO—had their views taken into consideration in human rights development and implementation. While a bevy of nongovernmental organizations would hold official relationships with WHO in advancing medical science, WHO collaboration with nongovernmental organizations for human rights advancement centered around the

⁶⁶ Roscam Abbing HDC. *International Organizations in Europe and the Right to Health Care*. Deventer, The Netherlands: Kluwer. 1979.

World Medical Association, founded in 1946 as the first international medical organization,⁶⁷ 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.⁶⁸

II. Theory & Methods

This study examines how WHO has translated evolving health discourses into human rights norms through international law. Under the hypothesis that *human rights norms for health have evolved over time and in relation to developments in global public health discourses within WHO*, this study looks historically at the association between legal norms of the right to health and health discourses of WHO, researching the political processes that led to the internationalization of WHO's health discourses in human rights law and the subsequent shifts in international health jurisprudence based on changes in WHO's discourse regarding health threats, theories, and technologies. To do so, this study defines the scope and content of health rights based on state international legal obligations, looking not solely to international law as the foundation of such rights but also to the UN debates that preceded each codification of the right to health in international legal discourse. Such a model implicates the study of law not simply as the content of adopted treaties or jurisprudence but also of the underlying processes and

⁶⁷ Routley TC. Aims and objects of the World Medical Association. *World Medical Association Bulletin*. 1949;1:18-19.

⁶⁸ Z. Bankowski, Levine RJ. *Ethics and Research on Human Subjects: International Guidelines*. Geneva, Switzerland: CIOMS; 1993.

interactive dynamics of adopting and implementing norms for health rights, examining the international environment for legal reform through WHO's rights-based discourses.

To understand the processes and dynamics of an evolving right to health, WHO presents a uniquely situated case study, with WHO having a preeminent impact on both (1) the development and implementation of international health rights and (2) the creation of global consensus in public health discourse. First, the UN and its specialized agencies, as the principal international legal authority, hold a central role in the development of human rights language and the implementation of these norms, guiding and interpreting the human rights regime as it is put into law and law into practice.⁶⁹ Within the UN system, WHO retains presumptive authority in all health-related matters within its constitutional purview.⁷⁰ At the forefront of health diplomacy, WHO stands at the crossroads of health rights, privy to all international communications related to the right to health and capable of shaping norms in health rights through established UN decision-making hierarchies, enabling or stymieing their realization. For example, through UN preparatory documents, WHO is often given the initial opportunity to frame the human rights norms related to health, allowing it to shape the codification of the right to health; once those norms are codified, WHO's role continues, working through ECOSOC to review, adjudicate, and supervise national and international measures of

⁶⁹ Alston P. *The United Nations and Human Rights: A Critical Appraisal*. Oxford: Clarendon; 1992.

⁷⁰ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979.

implementation.⁷¹ Second, in considering WHO's role in the creation of global consensus in public health discourse, WHO has long been a leader in the development of global public health discourses, acting in an agenda-setting capacity as a health representative of the community of states.⁷² Through a stable organizational structure and administrative apparatus, WHO has amassed unparalleled expertise in the field of public health and carried out a large number of public health research studies.⁷³ With this centralized expertise building institutional authority in public health, scholars look to WHO to resolve technical public health issues impervious to resolution at the national level, with WHO acting as “a catalytic agent, a center for debate and policy formulation and codification.”⁷⁴ As the world’s leading supervisory body for health, WHO is institutionally situated to translate this global consensus in public health discourse into the legal language and programmatic implementation of health rights. With changing health threats, theories, and technologies creating new demands and challenging existing international human rights orders,⁷⁵ WHO bears primary responsibility for channeling

⁷¹ Sohn LB. Human rights: Their implementation and supervision by the United Nations. In Meron T. *Human Rights in International Law: Legal and Policy Issues*. Oxford: Clarendon Press; 1985:369-401.

⁷² Jamison DT, Frenk J, Knaul F. International collective action in health: objectives, functions, and rationale. *Lancet*. 1998 Feb 14;351(9101):514-517.

⁷³ Abbott KW, Snidal D. Why states act through formal international organizations. *Journal of Conflict Resolution*. 1998;42:3-32.

⁷⁴ Taylor AL. Making the World Health Organization work: A legal framework for universal access to the conditions for health. *American Journal of Law and Medicine*. 1992;18:301-346: 338.

⁷⁵ Brody EB. *Biomedical Technology and Human Rights*. Paris: UNESCO; 1993.

these changing health discourses into evolving legal conceptualizations of human rights for health.

In examining this dynamic, the present research is grounded in the methodological understanding that (1) the legal language of human rights is a means by which states support their shared norms and (2) the discourse of health is a means by which scholars, practitioners, and advocates advance explanations for health threats, theories, and technologies. The relationship between these two dialectics will form the basis of this dissertation research, examining the effect of changing WHO health discourses on international legal norms for the human right to health. To complete this examination, the present study will employ legal research methods to analyze changes in the international legal language of health rights, assessing underlying health discourses through discourse analysis of the related WHO and UN communications.

A. Legal Analysis

The study of legal norms has long been a focus of study in political science, with the understanding that law is a social phenomenon, a dynamic process of normative development rather than a static body of rules. In concretizing these norms, the end of the Second World War brought with it an understanding that human rights norms must be codified, enforcing morality through international law.⁷⁶⁻⁷⁷ Given the law's role in memorializing and reifying these human rights norms,⁷⁸ legal analysis is

⁷⁶ Carr EH. *The Twenty Years Crisis of 1919-1939: An Introduction to the Study of International Relations*. 2d ed. New York: Macmillan; 1946.

⁷⁷ Drost PN. *Human Rights as Legal Rights*. Leiden: A.W. Sijthoff; 1951.

⁷⁸ Mill JS. *A System of Logic Ratiocinative and Inductive*. 8th ed. 1881, 1952.

well suited to studying the politically constructed evolution of ideas as they are manifested in international law.⁷⁹ Within this methodological framework, the present dissertation research charts the changing meaning of these historically contingent norms as they are codified in the right to health under international law.

While it is generally accepted that human rights evolve in response to ‘standard threats,’⁸⁰ few before have attempted to study the normative evolution of a human right.⁸¹ This dearth of research is pronounced in health, where no previous scholar has attempted to trace the evolution of the norms of a right to health as they are developed in human rights under international law and implemented through international organizations.

Viewing rights as state-constructed legal principles,⁸² it becomes possible to chronicle the ideational development through which human rights come into being and evolve over time, employing social scientific research to provide causal theories for the law’s association with social norms.⁸³ From this positivist legal framework has arisen a

⁷⁹ Donnelly J. International human rights: A regime analysis. *International Organization*. 1986;40:599-642.

⁸⁰ Shue H. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. New Jersey: Princeton University Press; 1980.

⁸¹ Lauren PG. *The Evolution of International Human Rights*. Philadelphia: University of Pennsylvania Press. 2003.

⁸² Slaughter AM, Tulumello AS, Wood S. International law and international relations theory: A new generation of interdisciplinary scholarship. *American Journal of International Law*. 1998;92:367-397.

⁸³ Riles A. Representing in-between: Law, anthropology, and the rhetoric of interdisciplinarity. *University of Illinois Law Review*. 1994;1994:597-651.

burgeoning stream of interdisciplinary legal research,⁸⁴ employing theories of international relations to explain, *inter alia*, the social construction of shared global norms under constructivist human rights theory.⁸⁵ Pursuant to this constructivist theory, norms—collective understandings of appropriate behavior—have explanatory force independent of state situational constraints, and thus, international law relies on ideas, values, and norms that exist independent of the distribution of state power.⁸⁶⁻⁸⁷ With these norms developed through the UN, these institutional dialogues create international policy to govern state behavior and national policy to frame state programs.⁸⁸ Emphasizing an interaction between state interests and social structures, constructivism finds that state goals are endogenous to interactions with these UN institutions, with norms determining state preferences in both goals and the means to achieve those goals.⁸⁹

Under a societal approach to constructivism, this study situates ‘regulative norms’—norms ordering state behavior—in the formalistic language of human rights,

⁸⁴ Slaughter AM. International law and international relations theory: A dual agenda. *American Journal of International Law*. 1993;87:205-239.

⁸⁵ Koh HH. Why do nations obey international law?. *Yale Law Journal*. 1997;106:2599-2659.

⁸⁶ Finnemore M. *Defining National Interests in International Society*. Ithaca, NY: Cornell University Press; 1996.

⁸⁷ Finnemore M, Sikkink K. International norm dynamics and political change. *International Organization*. 1998;52:887-917.

⁸⁸ Paul JCN. The United Nations and the creation of an international law of development. *Harvard International Law Journal*. 1995;36:307-328.

⁸⁹ Kratochwill F, Ruggie JG. International organization: A state of the art on an art of the state. *International Organization*. 1986;40:753-775.

viewing the development of health rights as an iterative process indicative of a global set of norms.⁹⁰ These international norms for health rights are encapsulated in UN documents and treaties and then elaborated through treaty enforcement bodies, international conferences and declarations, state practice, and judicial enforcement.⁹¹ In this sense, international law reflects the negotiated codification of global health norms already in existence and reifies those norms until revised through normative evolution and subsequent legislative or jurisprudential amendment.⁹² During this process of normative evolution, the UN and its specialized agencies guide state and nongovernmental representatives to develop and harmonize norms, negotiating potentially conflicting norms and advancing these ideas about collective morality into international legal obligations, which are then implemented through national law and internalized by state practice.⁹³

To determine the content of these legal norms, this study employs international legal research and legal analysis to elucidate the normative content of the right to health. These expressions and components of health rights are found in internationally recognized sources of international law, including: (1) formal international law (international treaties and conventions, international custom, general principles of law,

⁹⁰ Ruggie JG. What makes the world hang together? Neo-utilitarianism and the social constructivist challenge. *International Organization*. 1998;54:855-885.

⁹¹ Slaughter AM, Tulumello AS, Wood S. *International law and international relations theory: A new generation of interdisciplinary scholarship*. *American Journal of International Law*. 1998;92:367-397.

⁹² Alston P. Conjuring up new human rights: A proposal for quality control. *American Journal of International Law*. 1984;78:607-621.

⁹³ Koh HH. Why do nations obey international law?. *Yale Law Journal*. 1997;106:2599-2659.

and judicial decisions and the writings of scholars), (2) “soft law” (non-binding declarations), and (3) independent scholarship. Correspondingly, in uncovering these legal obligations, this study looked to: (1) published treaty language and official preparatory documents (*travaux préparatoire*) (formally indexed by the UN); (2) official international conference proceedings and programs of action (available electronically); (3) UN treaty and official committee archives (collected by professional archivists and stored by the UN or one of its specialized agencies); and (4) legal scholarship from multiple country contexts (collected and categorized by the Committee on Economic, Social and Cultural Rights and Georgetown Law Center’s O’Neill Institute for National and Global Health Law). Where there were gaps in the documentary record of legal norms, these sources were clarified, complemented, and supplemented by semi-structured interviews with key informants—identified through a snowball sample of leading policy actors at international and non-governmental organizations—who had key roles in the development and implementation of the right to health.

B. Discourse Analysis

Flowing from this understanding of the changing legal norms inherent in the right to health, the purpose of this study is to examine how these legal norms evolve in response to the WHO discourses that underlie the substance of health rights – framing themes for discourse analysis in the semantic content shifts of WHO health discourses. In understanding the evolution of a human right for health, for example, this study views the international legal language of the right to health to be defined both by historically prior legal language (intertextuality constraints) and by WHO health discourses exterior

to the law (interdiscursive relations).⁹⁴ To examine the underlying ideational mechanisms at each stage of legal norm advancement, it is necessary to examine the microfoundations of these normative turns through historical research and discourse analysis.⁹⁵ This historical research of health discourse examines how WHO's health debates support or inhibit efforts to bring health knowledge to the development of health rights. Tracing the history of the ideas composing the right to health, this research studies the manner in which health discourses are translated into the language of human rights through WHO's participation in the development and implementation of health rights, uncovering the complex and coordinating interactions of these discourses in changing the meaning and application of human rights for health. To do so, this study looks to official WHO and UN clarificatory documents, preparatory documents, and secondary texts—those scientific, medical, and public health writings preceding and immediately following each respective international legal standard for health rights. Drawing on the medical and public health literatures surrounding these facets of health discourse, this study employs discourse analysis to analyze the ways in which WHO employed health knowledge to alter the meaning of the ‘highest attainable standard of health’ and the scope of the human right that upholds it.

In doing so, this discourse analysis assesses WHO's debates on health and human rights, providing an understanding of why the specific language of health rights was

⁹⁴ Foucault M. *The Archaeology of Knowledge*. A. Sheridan-Smith trans. 1972.

⁹⁵ Cook RJ, Dickens BM, Fathalla ME. *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*. New York: Oxford University Press; 2003.

formed and how it operated.⁹⁶ Eschewing essentialism (the persistence of meaning over time), discourse analysis allows for the exploration of the changing meaning of the concept of health, looking to WHO's social construction of that concept vis-à-vis health rights. Through an analysis of the conceptual language underlying international law, it is possible to construct WHO actors' social construction of health rights, situating international legal texts in the historical context of, for example, their legal, political science, or medical/public health literatures.⁹⁷ It is these types of literatures that make up discourses, “[a] group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures.”⁹⁸ As such, health discourses within WHO provide for the investigation and analysis of health threats, theories, and technologies and, correspondingly, the development of health rights norms in international law.⁹⁹

This study examines how constituent norms of health rights have evolved in international law in response to underlying health discourses, particularly those changing WHO discourses on the relative importance of individual medicine services and primary health care in improving the public's health. Secondary texts in medicine and public health have particular relevance in uncovering the discourses underlying international law

⁹⁶ Gee JP. *An Introduction to Discourse Analysis: Theory and Method*. 2d ed. New York: Routledge; 2005.

⁹⁷ Wiener A. Constructivism: The limits of bridging gaps. *Journal of International Relations and Development*. 2003;6: 252-275: 253.

⁹⁸ Lupton D. Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*. 1992;16:145-150. 145.

⁹⁹ Milliken J. The study of discourse in international relations: A critique of research and methods. *European Journal of International Relations*. 1999;5:225-254.

for health. If human rights for health evolve, it is these ancillary texts—legal and non-legal alike—that both identify WHO practice with regard to rights and provide historically-situated evidence of the development and implementation of those norms. With specific regard to the content of health rights, medical and public health developments have identified threats to health, framed the theories by which health is defined, and shaped what states can do in applying technologies to assure healthy conditions. In applying discourse analysis to assess how WHO’s communications shape the scope and content of the right to health, this research examines the shared language of health threats, theories, and technologies in medicine and public health at specific moments in time surrounding codifications of health rights. Guided by various “building tasks” of language—significance, relationships, politics, connections, knowledge, and sign systems¹⁰⁰—this analysis has traced the historical evolution of WHO’s language in medicine and public health and how such mutually agreed-upon language reflects and constructs evolving states of health knowledge.¹⁰¹ Sampling WHO and UN documents and communications across medicine and public health, the process of discourse collection continued until theoretical saturation – when a complete range of themes was represented by the data.¹⁰² In reviewing this discursive data, the interpretation of identified themes—through an ordering of the building tasks and the central themes of

¹⁰⁰ Gee JP. *An Introduction to Discourse Analysis: Theory and Method*. 2d ed. New York: Routledge; 2005.

¹⁰¹ Schiffrin D, Tannen D, Hamilton HE. *The Handbook of Discourse Analysis*. Malden, Mass.: Blackwell; 2003.

¹⁰² Starks H, Trinidad SB. Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Res*. 2007;17:1372-1380.

the literatures¹⁰³—has resulted in a comprehensive analysis of the institutional mechanisms by which WHO has sought to translate health discourse into health rights.

III. Results – The Birth, Death, and Resurrection of Human Rights in WHO Programming: How Early Intransigence Toward Human Rights Crippled World Health Organization Efforts to Achieve Health for All

This part chronicles the political dynamics of WHO human rights programming, 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 advancement and implementation of human rights—finding either that WHO had an influential positive presence in the evolution of human rights discourse¹⁰⁴ or that public health and human rights always “evolved along parallel but distinctly separate tracks,” joined for the first time with the advent of the HIV/AIDS pandemic¹⁰⁵—both of these accounts present an incomplete history, overlooking the vital human rights role played by WHO in its early years and the consequences that resulted when WHO subsequently abnegated its authoritative role as a leading voice for health rights.

As highlighted in this historical narrative and analysis, although WHO was an early and forceful proponent of a rights-based approach to health, WHO came to

¹⁰³ Gee JP. *An Introduction to Discourse Analysis: Theory and Method*. 2d ed. New York: Routledge; 2005.

¹⁰⁴ Alston P. The United Nations’ specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights, *Columbia Journal of Transnational Law*. 1979;18:79-118: 117.

¹⁰⁵ Gruskin S, Mills EJ, Tarantola D. History, principles, and practice of health and human rights. *Lancet*. 2007;370:449-454: 449.

reposition itself as an exclusively technical organization, focusing solely on disease prevention and medical organization to the detriment of rights advancement. In the midst of the codification of the 1948 UDHR in the 1966 ICESCR, the WHO Secretariat walked away from its efforts to develop the international legal language of the right to health and implement 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 in the 1970s, its past neglect of rights-based strategies left it without the human rights obligations and legitimacy necessary to implement primary health care pursuant to the Declaration of Alma Ata. In a chronological series of subparts, these results describe WHO's early influence on human rights (1948-1953), subsequent neglect of human rights (1953-1973), and ultimate rediscovery of human rights as the basis of its Health for All strategy (1973-1979) – with these time periods corresponding with successive changes in WHO leadership and direction.

A. WHO Influences Human Rights (1948-1953)

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 United Nations and lay out WHO's mandate, programs, and priorities for global public health.¹⁰⁶ From the moment of this inauguration, WHO sought to pursue dual policy paths in its work: an extension of previous coordination in international health protection (including epidemiological surveillance, sanitary conventions, and standardization) and an ambitious rights-based project in national health promotion, both to bring the resources

¹⁰⁶ Goodman NM. First World Health Assembly. *Lancet*. 14 Aug. 1948. 265-266.

of science and medicine to bear on the major problems and neglected countries of the world and to establish national public health systems to address underlying determinants of health.¹⁰⁷

In the aftermath of the Second World War, a unique and unrepresentative moment in the history of ideas surrounding health, medical technologies—in the form of new physician practices, newly-discovered scientific therapies, and global epidemiologic surveillance systems—had created unlimited possibilities to extend and improve life.¹⁰⁸ These “miracles of modern medicine” were dramatically showcased by the wartime success of the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA), which had acted to provide basic medical services, medical and sanitation supplies, and DDT (dichloro-diphenyl-trichloroethane) to war-ravaged nations. Reflecting on this moment in the history of 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.”¹⁰⁹ Through the establishment of a permanent health secretariat in WHO, “newly-discovered scientific knowledge was to make possible and also to

¹⁰⁷ International Health or World Health?. *Lancet*. 14 Aug. 1948. 260.

¹⁰⁸ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Sijthoff & Noordhoff: Alphen aan den Rijn, The Netherlands. 1979.

¹⁰⁹ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971: 13.

provide the stimulus for more effective international health work,”¹¹⁰ with the technical functions of UNRRA and other international health organizations transferred to the Interim Commission of WHO and forming a foundation of WHO’s post-Constitution programming. As encapsulated in the faith of WHO’s first Director-General in achieving rights-based medical 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.’”¹¹¹

Notwithstanding this moment of exultation for the observed “miracles” of modern medical care, leading global public health officials continued to emphasize 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.”¹¹² Adopting the term ‘health care’ rather than ‘medical care’ as the basis of health discourse,¹¹³ public health practitioners sought to develop policy consensus that the full development of health requires both insurance for

¹¹⁰ World Health Organization. *The First Ten Years of the World Health Organization*. Geneva: World Health Organization; 1958: 37.

¹¹¹ Chisholm BC. Is the World Health Organisation succeeding in its work? In Pollak SW (Ed.) *Uphill: Nine Leading Figures on UN's Progress and Difficulties*. 24-33. London: United Nations Association; 1951.

¹¹² Sydenstricker E. *Health and Environment*. New York: McGraw-Hill; 1933: 85.

¹¹³ Grant JB. International trends in health care. *American Journal of Public Health*. 1948;38:381-397.

medical services¹¹⁴ and underlying conditions for, *inter alia*, adequate nutrition,¹¹⁵ housing,¹¹⁶ education,¹¹⁷ and social security.¹¹⁸ Looking to national governments to realize these economic, political, and social determinants of health, leading public health statesmen considered it to be “a truism” that “education and high economic status are of primary importance in the protection of health.”¹¹⁹ With the contemporaneous rise of national social welfare systems, it had become clear that health promotion, disease prevention, and rehabilitation required concerted government action through national health policies directed toward alleviating underlying determinants of health.¹²⁰ Based upon the successes of 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 export this developed world success to the developing world, observing that health “comes to underdeveloped areas only by patient

¹¹⁴ Canada House of Commons Special Committee on Social Security. *Health Insurance—Report of the Advisory Committee on Health Insurance Appointed by Order in Council P.C. 836, Feb. 5, 1942*. Ottawa: Government Printer; 1943.

¹¹⁵ Schultz TW. (Ed.) *Food for the World*. Chicago: University of Chicago Press; 1945.

¹¹⁶ American Public Health Association. *Housing for Health*. Lancaster, Pennsylvania: Science Press Printing; 1941.

¹¹⁷ Derryberry M. The role of health education in a public health program. *Public Health Reports*. 1947;62:1629-1641.

¹¹⁸ Robson WA. (Ed.) *Social Security*. London: George Allen & Unwin; 1945.

¹¹⁹ de Paula Souza GH. Today’s global frontiers in public health. *American Journal of Public Health*. 1945;35:111-114,112.

¹²⁰ Grant JB. International trends in health care. *American Journal of Public Health*. 1948;38:381-397.

training of public health personnel and the development of reasonably well-organized national and local public health departments.”¹²¹

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 and autonomy to the WHO Secretariat to design and fulfill program details.¹²²⁻¹²³ Transitioning from the international disease prevention emphasis of its predecessor organizations, WHO would carry out its programs to focus on stemming disease and promoting health at its source, seeking to coordinate and improve the development of national health systems through the pooling of international knowledge and experience on underlying determinants of health.¹²⁴ 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.”¹²⁵ To develop these public health services as part of national health systems—in accordance with the

¹²¹ Russell PF. International preventive medicine. *Scientific Monthly*. 6 Dec. 1950. 393-400:399.

¹²² The World Health Organization. *Yearbook of the United Nations*. 1947-1948:908-923.

¹²³ Doull JA, Kramer M. The first World Health Assembly. *Public Health Reports*. 1948;63:1379-1403.

¹²⁴ Masters, RD. *International Organization in the Field of Public Health*. Washington, DC; Carnegie Endowment; 1947.

¹²⁵ WHO Director-General. Explanatory memorandum. *WHO Official Records*. 1951;37:330.

Organization's explicit constitutional mandate and building on the Interim Commission's survey of national public health systems¹²⁶—WHO's work under its Expanded Programme of Technical Assistance for Economic Development would encompass the range of current 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 health¹²⁷—that WHO concerned itself with what it considered an “inseparable triad” for designing health policy – “the interdependence of social, economic and health problems.”¹²⁸ To address these

¹²⁶ The World Health Organization. *Yearbook of the United Nations*. 1947-1948:908-923.

¹²⁷ Crew FAE. *Measurements of the Public Health: Essays on Social Medicine*. Edinburgh: Oliver and Boyd; 1948.

¹²⁸ Work of WHO 1952 – Annual Report of the Director-General to the World Health Assembly and to the United Nations. *Official Records of the World Health Organization*. No. 45. E/2416 Add. 1.

interrelated determinants of health through comprehensive approaches to policy, WHO sought to coordinate interdisciplinary approaches to public health through *ad hoc* collaborations with these other agencies and organizations, often with other organizations providing funding for WHO personnel and programming.¹²⁹⁻¹³⁰ Although many agencies—nongovernmental, governmental, and intergovernmental—would be enlisted in the post-War public health endeavor, WHO took the lead in formulating the policy and coordinating action, with the US 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.”¹³¹ With a synoptic view of underlying determinants of health and a predilection toward interagency collaboration to attain its multi-sectoral health goals, the WHO Secretariat sought to work with the UN to apply human rights for health.

In fulfilling its global health mission under human rights frameworks, WHO’s early years—under the leadership of Brock Chisholm, the Canadian Executive Secretary of the Interim Commission and then first WHO Director-General—were marked by the Organization’s active role in (1) the drafting and implementation of human rights treaties, working with the UN and other specialized agencies to expand human rights principles

¹²⁹ Work of WHO 1952 – Annual Report of the Director-General to the World Health Assembly and to the United Nations. *Official Records of the World Health Organization*. No. 45. E/2416 Add. 1.

¹³⁰ E.g., Keeney SM. Two cooperative projects of WHO and UNICEF. *Public Health Reports*. 1953;68(6):606-608.

¹³¹ van Zile Hyde H. The nature of the World Health Organization. *Public Health Reports*. 1953;68(6):601-605: 605.

and conduct joint health programs,¹³² and (2) the incorporation of human rights in its operations, seeking to achieve the “highest attainable standard” of health through public health programs (a) focusing on the benefits of scientific progress and (b) emphasizing socioeconomic underlying determinants of health.¹³³ To accomplish this, WHO distinguished itself as an active participant in the development of legal standards for human rights and the codification of international law for public health. During this period, WHO stayed apprised of the work of the UN Division of Human Rights, and likewise, the Division of Human Rights sought to stay apprised of all WHO activities in global health, finding these activities germane to the objectives set forth in article 25 of the UDHR.¹³⁴ To accomplish this mutually beneficial cooperation for health rights, the main channel of human rights communication between the UN and WHO came in relation to translating the rights enumerated in the UDHR into legally-enforceable covenants, first in the draft International Covenant on Human Rights and subsequently (with the decision to disaggregate the rights of the draft International Covenant on Human Rights into two separate covenants) in the ICESCR. Through this dedicated cooperation in the development and implementation of health rights, WHO 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.

¹³² E.g., International campaign against Tuberculosis. *Lancet*. 27 Nov. 1948: 855.

¹³³ E.g., Balfour MC. Problems in health promotion in the Far East. *The Milbank Memorial Fund Quarterly*. 1950;28(1):84-95.

¹³⁴ Memorandum from UN Division of Human rights Director John P. Humphrey to UN Specialized Agencies Liaison Dagmar H. Schlesinger. 24 Jan. 1951.

1. Draft International Covenant on Human Rights – Human Experimentation

Even before the completion of the UDHR, it became clear that the UDHR, as a nonbinding declaration, would need to be supplemented by a binding covenant; however, the initial spirit of unity inherent in these early post-War agreements deteriorated upon the intransigence of conflicting priorities and conceptualizations of human rights. Many western states had steadfastly objected to the inclusion of economic, social and cultural rights in the draft International Covenant on Human Rights – questioning their origin in natural law; finding it impossible “to define such rights and any permissible limitations of them with sufficient precision to form the subject of international obligations;” and noting that the realization of these rights already fell under the purview of the specialized agencies.¹³⁵ Although the newly formed Socialist bloc would seek to advance its ideological tenet of economic equity by declaring that economic and social rights “warranted first priority and that, upon their realization, it would then be possible to foster civil and political rights,”¹³⁶ the financial burdens of these legally enforceable economic and social rights fomented disunity in the human rights framework of the UDHR. As such, preliminary drafts of the International Covenant on Human Rights were restricted to civil and political rights, excluding the economic, social and cultural rights of the UDHR – including the right to health.

¹³⁵ Commission on Human Rights. Sixth Session. Compilation of the Comments of Governments on the Draft International Covenant on Human Rights and on the Proposed Additional Articles. E/CN.4/365. 22 Mar. 1950.

¹³⁶ Mazur RE. Realization or deprivation of the right to development under globalization? Debt, structural adjustment, and poverty reduction programs. *GeoJournal*. 2004;60(1):61-71: 62.

Even in the absence of discussion on a right to health, WHO remained involved in human rights discussions on civil and political rights but was confined in its involvement to issues surrounding human experimentation. For WHO, human experimentation held strong resonance in planning for the future of medicine. In the aftermath of the War, 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.”¹³⁷ Given a heightened international focus on medical experimentation following the Second World War—particularly given the prominence of the so-called *Doctors Trial*, prosecuting those Nazi physicians who participated in genocide and medical experimentation and creating international law for medical practice in the Nuremberg Code¹³⁸—WHO focused much of its human rights capital on limitation to medical experimentation.¹³⁹⁻¹⁴⁰

Originally drafted as article 6, this prohibition held: “No one shall be subjected to any form of physical mutilation or medical or scientific experimentation against his will.” With state suggestions that this prohibition include exceptions for protecting individual

¹³⁷ United States v. Karl Brandt. *Trials of War Criminals Before the Nuremberg Military Tribunals*; 1948. In Katz J. *Experimentation with Human Beings: The Authority of the Investigator, Subject, Professions, and State in the Human Experimentation Process*; 1972: 296.

¹³⁸ The Nuremberg Code. In Annas GJ, Grodin MA. *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. 1992.

¹³⁹ Bassiouni MC, Baffes TG, Evrard JT. An appraisal of human experimentation in international law and practice: The need for international regulation of human experimentation. *Journal of Criminal Law and Criminology*. 1981;72:1597-1666.

¹⁴⁰ Annas GJ, Grodin MA. Medical ethics and human rights: Legacies of Nuremberg, *Hofstra Law and Policy Symposium*. 1999;3:111-124.

and public health, the UN Commission on Human Rights requested, given that this article “gives rise to many problems of a medical nature,” that WHO provide initial “recommendations concerning the form of the article before the Commission takes any further action.”¹⁴¹ In providing these comments for its sixth session, the Commission specifically requested that WHO “take 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.”¹⁴²

Cognizant of these previous atrocities but fearful that restrictions on medical experimentation “would hinder genuine medical progress,”¹⁴³ WHO incorporated in its deliberations its nongovernmental partners, including the World Medical Association and International Council of Nurses.¹⁴⁴ With the World Medical Association (1) finding the language “without his free consent” more appropriate than “against his will” and (2) holding an interest in authorizing a physician to take necessary lifesaving action for a patient who cannot consent, it proposed that the language of the article be modified to: “No-one shall be subjected without his free consent either to medical or scientific experimentation or to physical mutilation except, in his own interest, in case of emergency and when unconscious.” (For similar reasons, the International Council of

¹⁴¹ Letter from UN Assistant Secretary-General Henri Laugier to WHO Director-General Brock Chisholm. SOA 317-1-01EL. 1 June 1949.

¹⁴² *Id.*

¹⁴³ Roscam Abbing HDC. *International Organizations in Europe and the Right to Health Care*. Deventer, The Netherlands: Kluwer; 1979:131.

¹⁴⁴ Letter from World Medical Association Secretary General Louis H. Bauer to UN Division of Human Rights Director John Humphreys. 23 Aug. 1949.

Nurses proposed the more permissive language: “No-one shall be subjected against his will to physical mutilation or medical or scientific experiment not required by his state of health both physical and mental.”)¹⁴⁵

When WHO addressed this issue during the January 1950 meeting of its Executive Board,¹⁴⁶ the Executive Board’s working group on medical experimentation was unable to reach consensus, with the majority of the working group fearing that legitimate research would be stifled by explicit prohibitions on medical experimentation and recommending that such an article be omitted entirely.¹⁴⁷ Despite the issuance of a minority report—finding the prohibitions insufficiently strong in protecting a right of informed consent and suggesting a more nuanced text for article 7¹⁴⁸—the Executive Board adopted the majority finding, with the WHO Secretariat responding to the UN by arguing for the exclusion of article 7 on medical experimentation but nevertheless finding its prohibited conduct to fall under the scope of article 5’s torture provision and thereby to be unnecessary:

- (1) Article 5 of the Declaration acts as a sufficient deterrent against the type of conduct that Article 7 of the Covenant is destined to prevent.
- (2) It is considered extremely difficult to present an Article, which while preventing improper medical intervention and experimentation would not

¹⁴⁵ WHO Executive Board. Fifth Session. Proposed Rewording of Article 7 of the International Covenant of Human Rights. EB5/62. 30 Dec. 1949.

¹⁴⁶ Letter from WHO Acting Director-General R. Gautier to UN Assistant Secretary-General Henri Laugier. 957-3-6. 1 Dec. 1949.

¹⁴⁷ WHO EB5/98. EB Resolution EB5/86.Rev.2, p.46 – Off. Rec. WHO, 25, p. 17. 1950.

¹⁴⁸ Rapport de la Delegation des Nations Unies sur la Cinquieme Session du Conseil Executif de l’OMS (Geneve, 16 janvier – 2 fevrier 1950). 17 Mar. 1950.

also at the same time act to the prejudice of legitimate medical and social needs.¹⁴⁹

In partial response to the concerns of WHO's Executive Board, the Commission on Human Rights, temporarily moving the substance of Article 7 to Article 4, revised the prohibitions on medical experimentation to read:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected against his will to medical or scientific experimentation involving risk, where such is not required by his state of physical or mental health.

As the UN Division of Human Rights explained this revised language: "The words 'in particular' were deliberately chosen in order to indicate that this is not a provision which intends to restrict generally scientific activities but only cases of cruel, inhuman or degrading treatment which take the form of medical and scientific experimentation."¹⁵⁰

To clarify this intent not to quash legitimate medical practice, states elaborated the caveat to this prohibition where such experimentation is "required by his state of physical or mental health."

With this international legal language continuing to develop, the UN General Assembly sought to "find a formulation which, while outlawing criminal experimentation, would not hinder legitimate scientific or medical research as well as

¹⁴⁹ Letter from WHO Director-General Brock Chisholm to UN Acting Assistant Secretary-General Alva Myrdal. CC 4-6 Human Rights. 1 Feb. 1950.

¹⁵⁰ Letter from UN Division of Human Rights Assistant Director to Acting Permanent Delegate of Canada to the United Nations John W. Holmes. SOA 317/1/01(1)ES. 29 June 1950.

medical treatment required in the interest of the patient's health.”¹⁵¹ Whereas “the interest of the World Health Organization in Article 7 had ended with the report of the organization to the Commission on Human Rights,”¹⁵² the World Medical Association continued its involvement in the development of human rights norms for medical experimentation,¹⁵³ keeping the WHO Secretariat apprised of that involvement. Despite the official opposition of WHO’s Executive Board to expanding human rights to encompass medical experimentation¹⁵⁴—a losing battle given article 7’s ultimate language that “[i]n particular, no one shall be subjected without his free consent to medical or scientific experimentation” without the qualifying language of medical necessity (adopted by the Third Committee of the General Assembly in October 1958, 39-0, with 29 abstentions)—this experience shaped the WHO Secretariat’s active approach to human rights, and it was clear to UN observers that WHO sought a cooperative role with other UN organs in the field of human rights. Given continuing involvement and cooperation from nongovernmental organizations in medical experimentation—allowing the WHO Secretariat to distance itself from the uncompromising stance of its Executive Board—the WHO Secretariat would shift its attention to the consideration of positive human rights obligations for health.

¹⁵¹ Memorandum from UN Division of Human Rights Director John P. Humphrey to UN Under-Secretary for Special Political Affairs Sir Humphrey Trevelyan. SO 221/9(1). 20 Oct. 1958.

¹⁵² Letter from WHO New York Liaison Office Acting Director Mabel S. Ingalls to UN Division of Human Rights Acting Director Egon Schwelb. 20 Feb. 1951.

¹⁵³ Letter from WHO Director-General Brock Chisholm to UN Secretary-General. 17 Oct. 1951.

¹⁵⁴ Memorandum from WHO External Relations Chief to WHO LUN Director. Projet de Pacte des Droits de l’Homme. 4N64/372/1. 14 Oct. 1958.

Providing these additional opportunities for WHO incorporation in the human rights project, the UN General Assembly resolved in December 1950¹⁵⁵ to expand ECOSOC human rights deliberations to include economic, social and cultural rights in the draft International Covenant on Human Rights, affirming that “the enjoyment of civic and political freedoms and of economic, social and cultural rights are interconnected and interdependent” and seeking through the Commission on Human Rights “to obtain the cooperation” from specialized agencies in drafting articles within their respective purview.¹⁵⁶ In doing so, the Commission on Human Rights would take up legal obligations concerning economic, social and cultural rights in its 1951 session, giving WHO its first opportunity to influence the development and implementation of a human right to health.

2. Draft International Covenant on Human Rights – The Right to Health

In preparation for states to develop the scope and content of the right to health, the Commission on Human Rights requested that the UN Secretary-General submit a report to ECOSOC on the legal aspects of previous actions by the UN and its specialized agencies in relation to economic, social and cultural rights.¹⁵⁷⁻¹⁵⁸ To accomplish this, the

¹⁵⁵ United Nations General Assembly. Resolution 421(V). 4 Dec. 1950.

¹⁵⁶ ECOSOC. Resolution 349(XII). 23 Feb. 1951.

¹⁵⁷ UN Commission on Human Rights. Report of the Fifth Session. UN Doc E/CN.4/350. 23 June 1949.

¹⁵⁸ Memorandum from UN Acting Assistant Secretary-General, Legal Department A.H. Feller to UN Acting Assistant Secretary-General, Department of Social Affairs Aly Hyrdal. Request by the Commission on Human Rights to the Secretary-General for a

UN Division of Human Rights developed a survey of activities within the scope of articles 22 to 27 of the UDHR, summarizing information contributed by the executives of UN specialized agencies: the ILO, UNESCO, FAO, and WHO. Reaching out to WHO on such cooperative opportunities with the Commission on Human Rights,¹⁵⁹ Director-General Chisholm responded enthusiastically in January 1951, quoting from the preambular language of the WHO Constitution (preambular language that the Director-General had drafted personally while serving as the rapporteur of the 1946 Technical Preparatory Committee¹⁶⁰) 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.” To this cooperative end, Director-General Chisholm concluded his reflections on WHO’s human rights mission:

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

legal report on Articles 24 and 25 to the Draft International Covenant on Human Rights.
23 May 1950.

¹⁵⁹ Letter from UN Assistant Secretary-General H. Laugier to WHO Director-General Brock Chisholm. SOA 317/1/01(2). 3 Jan. 1951.

¹⁶⁰ Ascher C. Chisholm of WHO. *The Survey*. 1952;Feb.:70-73.

WHO to be guided by this fundamental relationship in planning its work with governments as well as with other international organizations.¹⁶¹

With specialized agencies responding favorably to the UN's request for cooperation,¹⁶² WHO responded accordingly to the UN's subsequent request for comments on the scope of articles 22 to 27,¹⁶³ following up on the Director-General's response 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, to child welfare and maternal and child health clinics, to medical and nursing education and research, to international health policy—noting specific joint WHO activities with ILO, FAO, UNICEF, and UNESCO.¹⁶⁴ From this, the Commission on Human Rights revised its survey of the activities of specialized agencies, noting agency activities and interagency collaborations with regard to article 25's declaration of rights to underlying determinants of health, including adequate food, clothing, housing, medical care, and social security:

¹⁶¹ Letter from WHO Director-General Brock Chisholm to UN Assistant Secretary-General H. Laugier. SOA 317/1/01(2). 12 Jan. 1951.

¹⁶² Alston P. The United Nations' specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights. *Columbia Journal of Transnational Law*. 1979;18:79-118.

¹⁶³ Letter from UN Assistant Secretary-General H. Laugier to WHO Director-General Brock Chisholm. SOA 317/1/01(2). 19 Jan. 1951.

¹⁶⁴ Letter from WHO Division of Co-ordination of Planning and Liaison William P. Forrest to UN Assistant Secretary-General Henri Laugier. SOA 317/1/01(2). 8 Feb. 1951.

	Food	Clothing	Housing	Medical Care	Social Security
UN Agencies Concerned	FAO ILO WHO Trusteeship Council	UNICEF United Nations Relief for Palestine International Refugee Organization ILO	ILO WHO UN Social Commission Economic Commission for Europe FAO	UN WHO ILO	ILO UN Advisory Social Welfare Services ¹⁶⁵⁻¹⁶⁶

Given WHO's response and the UN's recognition of WHO's wide-ranging involvement, WHO was poised to play a crucial role in the development and implementation of state obligations to realize underlying determinants of health through national public health systems.

a. Commission on Human Rights

Expanding upon this undertaking with regard to the right to health, Director-General Chisholm reiterated in March 1951 letter to the UN Secretary-General that WHO "will advise [sic] the Commission [on Human Rights] on technical matters relating to health which may arise in the course of the Commission's work and will co-operate with

¹⁶⁵ Commission on Human Rights. Seventh Session. Agenda Item 3. 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: Report by the Secretary-General. E/CN.4/364. ¶¶121-131. 17 Mar. 1951.

¹⁶⁶ Commission on Human Rights. Seventh Session. Agenda Item 3. 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: Report by the Secretary-General. E/CN.4/364/Add.1. ¶¶ 31-41. 1 Mar. 1951.

the United Nations, as appropriate, in assistance to governments,”¹⁶⁷ with the Assistant Director-General writing the same day to the Assistant Secretary-General to go beyond technical matters and note that the WHO Secretariat would review its position on the right to health at the next Executive Board meeting.¹⁶⁸⁻¹⁶⁹ Pursuant to this cooperation, arrangements were made for WHO to send to the Commission’s June 1951 meeting a large Secretariat delegation, consisting of the Assistant Director-General, the Director of the Division of Organization of Public Health Services, the Director of the Division of Co-ordination of Planning, and the WHO Liaison to the UN.¹⁷⁰ Discouraged by WHO’s expansive foray into human rights policy, the United States Representative to the WHO Executive Board wrote to the Director-General, expressing 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 guarantees by passing appropriate legislation. On the other hand, in order to secure economic and social

¹⁶⁷ Letter from WHO Director General to UN Secretary General. Available at ECOSOC E/1880/Add3.

¹⁶⁸ Letter from WHO Assistant Director-General P. Dorolle to UN Assistant Secretary-General H. Laugier. 7 Mar. 1951.

¹⁶⁹ Memorandum from UN Director of Division of Human Rights John P. Humphrey to UN Assistant Director of Division of Human Rights Egon Scwelb. 11 July 1951.

¹⁷⁰ Letter from UN Acting Assistant Secretary-General Leon Steinig to WHO Assistant Director-General P. Dorolle. 23 Mar. 1951.

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 the 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 enforceable rights for health services.¹⁷¹

Notwithstanding such suggestions, WHO submitted suggested language on April 18, 1951 that implicitly rejected the US position on underlying determinants of health:

[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.

In deference to the position of the United States, however, the WHO suggestion clarifies that “some Governments with immense financial resources can concentrate on highly specialized problems and provide measures which only benefit a very small number of

¹⁷¹ Letter from US Representative to WHO Executive Board H. van Zile Hyde to WHO Director-General Brock Chisholm. 28 Mar. 1951.

people, while others have still to create a medical profession and health services before they can contemplate action of any kind.”¹⁷²

With Director-General Chisholm thereafter adding himself to lead the WHO delegation to the Commission on Human Rights, WHO suggested that the right to health should be couched in terms—drawn from the WHO Constitution and language abandoned in compromises with the UDHR¹⁷³⁻¹⁷⁴—that emphasize (1) a positive definition of health, (2) the importance of social measures in realizing underlying determinants of health, (3) governmental responsibility for health provision, and (4) the role of public health systems in creating measures for what would become “primary health care”:

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.

Government, having a responsibility for the health of their peoples, undertake to fulfil 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,

¹⁷² Draft International Covenant on Human Rights and Measures of Implementation. Suggestions Submitted by the Director-General of the World Health Organization. Commission on Human Rights. Seventh Session. Item 3(b). UN Document E/CN.4/544. 18 Apr. 1951.

¹⁷³ United Nations. *These Rights and Freedoms*. New York: UN Department of Public Information; 1950.

¹⁷⁴ Claude RP, Issel BW. Health, medicine and science in the Universal Declaration of Human Rights. *Health and Human Rights*. 1998;3(2):126-142.

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.¹⁷⁵

The Commission on Human Rights met in June 1951 to review substantive and implementation provisions concerning—among other economic, social and cultural rights—the right to health. WHO Director-General Chisholm began discussion on the right to health by pressing for the International Covenant on Human Rights to define health, advocating that delegates adopt the definition of “complete” health from the WHO Constitution. Given its widespread support among states parties to WHO, the Director-General advocated for this definition based upon a widespread public health consensus that health consists not only of a “negative conception of health as

¹⁷⁵ United Nations. Economic and Social Council. Commission on Human Rights. Seventh Session. E/CN.4/AC.14/2/Add.4. 27 April 1951.

representing simply freedom from disease.”¹⁷⁶ In the wake of this impassioned plea for health promotion and underlying determinants of health within the right to health, and in accordance with WHO’s written proposal, delegates turned to negotiations over the precise language of this right, whereupon state delegates proposed the major amendments summarized in the table below:¹⁷⁷

¹⁷⁶ United Nations. Economic and Social Council. Commission on Human Rights. Seventh Session. E/CN.4/SR.223. 13 June 1951.

¹⁷⁷ Commission on Human Rights. Report of the Seventh Session. E/1992.

WHO Proposal (4/18/51)	Egypt Proposal (5/2/51) / Chile Proposal (5/2/51) ([]) indicates deletion in Chile Proposal)	Denmark Proposal E/CN.4/542 (4/18/51)	USSR Amendment E/CN.4/583 (5/1/51)	UK Amendment E/CN.4/588 (5/2/51)	ECOSOC Submission
<p>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.</p> <p>Government, having a responsibility for the health of their peoples, undertake to fulfil that responsibility by providing adequate health and social measures.</p> <p>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:</p> <ul style="list-style-type: none"> 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. 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.] 	<p>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:</p> <ul style="list-style-type: none"> 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.] 	<p>Each State party hereto undertakes to combat disease and promote conditions which will assure the right of all its nationals to a medical service and medical attention in the event of sickness.</p>	<p>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.</p> <p>USA Amendment (5/2/51)</p> <p>The States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable.</p>	<p>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.</p> <p>↓ <i>Revised to accommodate WHO preferences</i></p> <p>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</p>	<p>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:</p> <ol style="list-style-type: none"> 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 consensus developing around WHO's proposal—providing simultaneously for the general recognition of a right to health in an opening paragraph with an enumeration of state obligations in subsequent paragraphs—the Commission was challenged primarily by dueling US and Soviet proposals. As a compromise, states adopted the US comprehensive amendment only as a replacement for the first paragraph of the WHO proposal. Likewise, with the Soviet Union critiquing the US proposal for failing to define obligations on governments, states included the Soviet comprehensive amendment on medical care only as an additional obligation on governments. With adoption of the amended Chilean proposal (11-5 (2 abstentions)), its subsequent amendment by the partial adoption of the US proposal (14-0 (3 abstentions)), and the rejection of the UK proposal (*as an amendment to the remainder of the Chilean proposal*, 8-7 (3 abstentions)), the Chairman put to vote each of the remaining paragraphs of the Chilean proposal, with each paragraph approved by wide margins.

By a final vote of 10-0 (8 abstentions)—the abstentions arising largely out of the draft article's provision for medical care¹⁷⁸—the Commission on Human Rights concluded on June 2, 1951 with the following text of 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

¹⁷⁸ The United States, France, China, Australia, the United Kingdom, Denmark, and Greece subsequently noted the reasons underlying each of their abstentions. United Nations. Economic and Social Council. Commission on Human Rights. Seventh Session. E/CN.4/SR.223. 13 June 1951.

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.¹⁷⁹

Rather than accepting the expansive definition of “complete” health from the WHO Constitution, however, the drafters of the Covenant—in conformity with a lack of definition for other rights¹⁸⁰—had reverted to the delimited “highest standard of health obtainable.” Despite this limitation, the revised draft of the right to health—amendments notwithstanding, the most detailed of the economic, social and cultural rights—would place extensive obligations on the state to create healthy conditions through public health systems, reflecting in legal rights the emphasis of WHO discourse on underlying determinants of health.¹⁸¹ To the extent that states continued to disagree on the measures

¹⁷⁹ Commission on Human Rights. Report of the Seventh Session. Annex I. E/1992.

¹⁸⁰ Nielsen HK. *The World Health Organisation: Implementing the Right to Health*. Copenhagen: Europublishers; 1999.

¹⁸¹ Despite this emphasis on improved standards of living, this language of the right to health—as with all economic, social and cultural rights—was conditioned on available national resources, with an “umbrella clause” in article 19 (in what would become the ‘principle of progressive realization’) finding that governments need only take steps “to

for implementing a right to health, this disagreement focused overwhelmingly on obligations for medical care, the only obligation not proposed by WHO.

b. WHO Executive Board

On June 7, 1951, the WHO Executive Board would meet in its Eighth Session to discuss for the first time WHO’s co-operation with the UN Commission on Human Rights, specifically the role that WHO would play in drafting the language of what would become the human right to health. With five days separating the meetings of the Commission on Human Rights and the Executive Board, Director-General Chisholm forwarded the 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 that concept” while highlighting the ways in which WHO could have a preeminent leadership role in implementing these concrete actions.¹⁸² In justifying the leadership role that WHO would be asked to undertake in implementing human rights, he found that “the provisions of the Covenant on Human Rights can and should be implemented through . . . the specialized agencies and the Agreements between the UN and the specialized agencies,”¹⁸³ admonishing the Executive Board not to disempower WHO by allowing non-technical UN organs to pass judgment over health

the maximum of their available resources with a view to achieving progressively the full realization of the rights recognized in this part of the present Covenant.”

¹⁸² World Health Organization. Executive Board. Eighth Session. EB8/39. 2 June 1951.

¹⁸³ Id.

issues.¹⁸⁴ While the Director-General remained concerned about lingering weaknesses in article 25—including duplications of the provisions of other articles; 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 state responsibility for underlying determinants of health—he advocated strong WHO authority for interpreting and supervising the implementation of the right to health’s domestic and international obligations.¹⁸⁵

In the ninety-minute 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 WHO, focusing its discussion on the substance of the right to health. Through this debate on the language of the article on the right to health—and with a member of the UN Human Rights Division present in an advisory role—the following changes in language were proposed for ECOSOC consideration (original argument in first bullet point, compromise arguments in the alternative included in subsequent bullet points; reasoning summarized in parenthetical statements):¹⁸⁶

EB Member (nationality)	Proposal
van Zile Hyde	<ul style="list-style-type: none"> • Delete entire second sentence of article 25 (<i>believing legislative measures to be</i>

¹⁸⁴ With regard to technical matters related to the right to health, the Director-General’s concern was that UN would enter matters within the competence of specialized agencies, with the Commission on Human Rights making recommendations to states and ECOSOC on health matters. United Nations. Report of the United Nations Delegation at the Eighth Session of the Executive Bard of the World Health Organization. SG/SA/39. 25 June 1951.

¹⁸⁵ World Health Organization. Executive Board. Eighth Session. EB8/39. 2 June 1951.

¹⁸⁶ Executive Board. Provisional Minutes of the Ninth Meeting. EB8/Min/9. 7 June 1951.

(US)	<i>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)</i>
Bravo (Chile)	<ul style="list-style-type: none"> If second sentence is included, the word “any” should be deleted.
Karunaratne (UK)	<ul style="list-style-type: none"> 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”
Daengsvang (Thailand)	<ul style="list-style-type: none"> Delete second sentence of article 25, beginning “with a view” (<i>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”</i>)
Canaperia (Italy)	<ul style="list-style-type: none"> Simply omit the word “legislative” in second sentence (<i>arguing that “take all necessary measures” would cover all points of view</i>)
Padua	<ul style="list-style-type: none"> Amend to read “to provide all necessary measures, including legislative measures...” (<i>thereby implying that legislation was a subordinate factor</i>)
Jafar (Pakistan)	<ul style="list-style-type: none"> Retain second sentence (<i>believing that legislative measures commit states parties to a definite course of action</i>)
Hurtado (Cuba)	<ul style="list-style-type: none"> Second sentence of article 25 should be amended to read: “...to take legislative and all other measures to promote...” (<i>agreeing with Bravo and arguing that it was not the task of the EB to redraft the article</i>)
Forrest (WHO Secretariat)	<ul style="list-style-type: none"> Second sentence of article 25 should be amended to read: “...to take legislative and other measures to promote...”

Much of the discussion centered on the various proposals of US representative van Zile Hyde, the same representative who earlier that year had cautioned against the Director-General’s expansive 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 the Commission on Human Rights—offered a series of compromise proposals to replace “legislative measures,” being rejected in his proposal for “all administrative, technical and legislative measures” before finding adoption (6-1 (8 abstentions)) for “legislative and other measures.” To ensure consensus in this retention of legislative measures for underlying determinants of health, the Director-General assured Executive Board members that his presentation of

this decision to ECOSOC would emphasize the importance placed on these “other measures.”¹⁸⁷ The Director-General would accommodate this Executive Board consensus by (1) reporting on this decision in a Commission on Human Rights survey of activities of specialized agencies in the economic, social and cultural rights¹⁸⁸ and (2) presenting this decision to the Thirteenth Session of ECOSOC, meeting in July-August 1951 to review the revised draft covenant.¹⁸⁹⁻¹⁹¹ While a right to health continued to lack the support of nongovernmental medical associations—prominently the World Medical Association, which criticized state obligations under the right to health and 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”¹⁹²—the WHO Secretariat was showing leadership inside WHO and throughout the UN for developing the language of this right and for implementing that language in its health programming.

¹⁸⁷ Memorandum from Margaret Kitchen to UN Director of Human Rights John P. Humphrey. Executive Board of the World Health Organization. 9 June 1951.

¹⁸⁸ Activities of the United Nations and the Specialized Agencies in the Field of Economic, Social and Cultural Rights. E/CN.4/364/Rev.1. Jan. 1952.

¹⁸⁹ World Health Organization. Executive Board. Resolution 50. Draft Covenant on Human Rights. EB8/R/50. 7 June 1951.

¹⁹⁰ United Nations. Report of the United Nations Delegation at the Eight Session of the Executive Board of the World Health Organization. SG/SA/39. 25 June 1951.

¹⁹¹ Letter from WHO Director, Division of Co-ordination of planning and Liaison W.P. Forrest to UN Director of Co-ordination for Specialized Agencies and Economic and Social Matters. 26 June 1951 (enclosing EB8/R/50).

¹⁹² Letter from World Medical Association Secretary-General Louis H. Bauer to UN Secreatry-General Trygvie Lie. 9 Oct. 1951 (quoting World Medical Association resolution).

This WHO leadership in health rights proved influential, as the UN 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 International Covenant.¹⁹³ When the UN Secretary-General published the results of the UN's survey of "Activities of the United Nations and of the Specialized Agencies in the Field of Economic, Social and Cultural Rights," the UN (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 several underlying determinants of health, and (3) recognized WHO for its health programs related to, among other things:

drawing 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,

¹⁹³ E.g., Memorandum from UN Division of Human Rights G. Brand to UN Division of Human Rights Assistant Director E. Schwelb. Some Further Reactions on the Articles on Economic, Social and Cultural Rights and Their Implementation Adopted by the Commission on Human Rights at Its Seventh Session. 9 June 1951.

study by expert committees and by individual research workers either in the field or at headquarters, and emergency material aid in epidemics...¹⁹⁴

While the UN's listed human rights activities for WHO were less widespread than for other specialized agencies—focused, much to the chagrin of WHO staff, on medical care—WHO would soon have an opportunity to advance a more encompassing right to health as the UN moved to develop a positive human rights framework within the ICESCR.

c. International Covenant on Economic, Social and Cultural Rights

On January 21, 1952, the Third Committee of the United Nations—for reasons grounded in the politics of the Cold War, in longstanding concerns about the universality of all human rights, and in Western objections to the practicability of economic rights¹⁹⁵—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 – the latter alone to codify a right to health.¹⁹⁶ In clarifying the details of this bifurcated human rights agenda, the General Assembly on February 5, 1952 requested ECOSOC:

¹⁹⁴ United Nations. Commission on Human Rights. Activities of the United Nations and of the Specialized Agencies in the Field of Economic, Social and Cultural Rights. E/CN.4/364/Rev.1. ¶ 131-132. Jan 1952.

¹⁹⁵ Letter from UN Division of Human Rights Director John Humphrey to UN Division of Human Rights Lin Mousheng. 3 Jan. 1952.

¹⁹⁶ United Nations General Assembly. Resolution 3031 (XI). 21 Jan. 1952.

to ask 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, the two covenants to contain, in order to emphasize the unity of the aim in view and to ensure respect for and observance of human rights, as many similar provisions as possible, particularly in so far as the reports to be submitted by States on the implementation of those rights are concerned.¹⁹⁷

By the same resolution, the General Assembly again called upon ECOSOC to request the Commission on Human Rights “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.”¹⁹⁸

In accordance with this and in preparation for the Commission on Human Rights’ April 1952 meeting to develop the draft Covenant on Economic, Social, and Cultural Rights, the WHO Executive Board met in its Ninth Session on February 4, 1952 to note the actions taken by the General Assembly and ECOSOC.¹⁹⁹ As part of this meeting, Director-General Chisholm sought approval from the Executive Board in proposing again

¹⁹⁷ United Nations General Assembly. Resolutions 543(VI)-547(VI). 5 Feb. 1952.

¹⁹⁸ United Nations General Assembly. Resolutions 543(VI)-547(VI). 5 Feb. 1952.

¹⁹⁹ World Health Organization. Executive Board. Resolution 102. Draft International Covenant on Human Rights. EB9/R/102. 4 Feb. 1952.

to the Commission on Human Rights that “reference be made to the positive definition [of health] contained in the preamble to the Constitution of WHO” and that—in addition to continuing emphasis on the organization of public health systems and training of health workers (deleted from WHO’s draft measures of implementation by the previous session of the Commission on Human Rights)—the right to health be amended to recategorize the measures to be taken by states in order to place greater emphasis on 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 their correction or mitigation by suitable care.²⁰⁰

However, because the General Assembly was still finalizing its resolutions to draft separate covenants (which it adopted the following day),²⁰¹ the Executive Board postponed discussion on the Director-General’s proposal,²⁰² focusing instead on requested implementation procedures for periodic state reporting to WHO on human

²⁰⁰ World Health Organization. Executive Board. Ninth Session. EB9/103. 29 Jan. 1952.

²⁰¹ Memorandum from UN Division of Human Rights Deputy Director E. Schwelb to UN Division of Human Rights Lin Mousheng. Final Stages of the Work of the General Assembly. 4 Feb. 1952.

²⁰² Report of the United Nations Delegation at the Ninth Session of the Executive Board of the World Health Organization. Geneva, 21 January - 4 February 1952. SG/SA/54. 7 Mar. 1952.

rights, national health legislation, and other health-related issues.²⁰³⁻²⁰⁴ With vibrant discussion on reporting procedures by the WHO Secretariat, UN 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.”²⁰⁵

The subsequent April-June 1952 session of the Commission on Human Rights sought to finalize the language of the right to health, then a yet-unnumbered article in the draft Covenant on Economic, Social and Cultural Rights.²⁰⁶ Although neither ECOSOC nor the General Assembly had discussed the right to health since the Commission’s previous session, the Council of Europe had commented on lessons to be drawn from the 1950 European Convention on Human Rights²⁰⁷ and member states had commented on lessons to be drawn from national legislation on the form and contents of the draft Covenant.²⁰⁸ To assist the Commission on Human Rights in its continued drafting, the UN Division of Human Rights prepared a memorandum summarizing observations from

²⁰³ World Health Organization. Executive Board. Resolution 105. International Digest of Health Legislation. EB9/R/105. 4 Feb. 1952.

²⁰⁴ Letter from WHO Deputy Director-General P. Dorolle to UN Assistant Secretary-General G. Georges-Picot. 27 Feb. 1952.

²⁰⁵ Report of the United Nations Delegation at the Ninth Session of the Executive Board of the World Health Organization. Geneva, 21 January - 4 February 1952. SG/SA/54. 7 Mar. 1952.

²⁰⁶ ECOSOC. Draft International Covenant on Human Rights and Measures of Implementation. E/CN.4/650. 10 Mar. 1952.

²⁰⁷ Letter from Council of Europe Secretariat-General A.H. Robertson to UN Human Rights Division Director Humphrey. 24 Jan. 1952.

²⁰⁸ E.g., Letter from United Kingdom Delegation to the United Nations to UN Secretary-General Trygve Lie. 95(1732/18/52E). 15 Mar. 1952.

governments, specialized agencies, and representatives, which—raising the WHO Executive Board's 1951 concerns on the right to health—included that:

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.²⁰⁹

In addition, the Division of Human Rights created a listing of observations and suggestions by nongovernmental organizations,²¹⁰ taking these similar observations into account in its drafting.

On May 15, 1952, the Commission on Human Rights reached debate on the right to health—then incorporated into article 13 of the draft International Covenant on Economic, Social and Cultural Rights—with state delegates presenting and successfully adopting the following amendments:

- 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.”²¹¹

²⁰⁹ Commission on Human Rights. Eighth Session. Draft International Covenant on Human Rights and Measures of Implementation: Provisions Concerning Economic, Social and Cultural Rights. E/CN.4/650. ¶ 32. 10 Mar. 1952.

²¹⁰ Memorandum from UN Division of Human Rights Lin Mousheng to UN Assistant Secretary General Guillaume Georges-Picot. Covenants on Human Rights: observations and Suggestions by Non-Governmental Organizations. 8 Apr. 1952. The most prominent of these observations on the right to health was the aforementioned criticism of the World Medical Association. Commission on Human Rights. Eighth Session. Draft International Covenants on Human Rights and Measures of Implementation. Observations and Suggestions by Non-Governmental Organizations. E/CN.4/660. 9 Apr. 1952.

²¹¹ E/CN.4/SR.296.

- United States – contract the second sentence (over the objection 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, specifically:
 - Replacing “With a view to implementing and safeguarding this right, each State Party hereto undertakes *to provide legislative measures* to promote 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...”²¹²

As a result these amendments—both in line with WHO’s original policy preferences—and in correcting a translation error by replacing ‘obtainable’ with ‘attainable standard of health,’²¹³ the draft language of the right to health was revised to:

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;

²¹² E/CN.4/L.79/rev.1.

²¹³ E/CN.4/SR.295.

- (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.²¹⁴

Given the repeated WHO suggestion that the new Covenant make reference to the definition of complete health contained in the WHO Constitution and that ‘legislative measures’ be expanded to ‘legislative and other measures,’ these WHO proposals had now been accepted by state delegates, which had reinserted WHO’s definition of “complete health” and expanded implementation in line with WHO’s original vision for legal and non-legal measures. WHO had achieved its vision for the right to health. However, with the Commission on Human Rights unable to complete its drafting of the two covenants,²¹⁵ ECOSOC authorized the Commission to take up again the development of the covenants at its 1953 session.²¹⁶ Although WHO would continue to update the UN

²¹⁴ Commission on Human Rights. Draft International Covenants on Human Rights and Measures of Implementation. Article ---* of the draft covenant on economic, social and cultural rights: Text adopted by the Commission at its 296th meeting, on 15 May 1952. E/CN.4/666/Add.9. 16 May 1952.

²¹⁵ Commission on Human Rights. Official Records of the Economic and Social Council. Fourteenth Session. Supplement No. 4. E/2256. Annex I.

²¹⁶ ECOSOC. Resolution 440 (XIV). Official Records of the Economic and Social Council. Fourteenth Session. Supp. 4 (Annex I). E/2256. 30 July 1952.

on its human rights reporting procedures into the latter half of 1952,²¹⁷ a 1953 change in leadership within the WHO Secretariat would alter its health priorities and lead it to revisit its commitment to the human rights enterprise.

B. WHO Neglects Human Rights (1953-1973)

Turning its attention to purely technical enterprises, which it approached through a medical lens, WHO began in 1953 to seek a vertical, disease-specific approach to health.²¹⁸ This technical agenda—under the leadership of Director-General Marcolino Gomes Candau, the Brazilian former Director of the Division of Organization of Public Health Services—focused largely (1) at the international level in 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 in country assistance through medical training and specific requests for medical technologies. 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.”²¹⁹ Thus, despite operating with more than triple its original staff and more than double its original funding,²²⁰ WHO’s program agenda shifted from its previous emphasis on global health priorities—

²¹⁷ Letter from WHO Director-General Brock Chisholm to UN Assistant Secretary-General Guillaume Georges-Picot. OER. 5 Dec. 1952.

²¹⁸ Brockington F. *World Health*. New York: Penguin. 1958.

²¹⁹ Gutteridge F. The World Health Organization: Its scope and achievements. *Temple Law Quarterly*. 1963;37(1):1-14: 8.

²²⁰ Hoole FW. *Politics and Budgeting in the World Health Organization*. Bloomington, Indiana: Indiana University Press; 1976.

which included leadership in communicable diseases in addition to noncommunicable diseases and underlying determinants of health—delegating country-based technical assistance programs to its six regional health offices,²²¹ abandoning collaborative health work with other UN specialized agencies,²²² and decentralizing public health authority within the UN system.²²³⁻²²⁴

In this context, discourses on health veered away from underlying determinants of health and 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.²²⁵ Given this medicalized conception of health care, a conception rooted in the “golden age of medicine” and scientific spirit of the post-War era, the achievements of medical progress had led developed countries to gradually lose interest in global health issues and public health systems in the years following the Second World War.²²⁶ With medical

²²¹ Berkov R. *The World Health Organization: A Study in Decentralized International Administration*. Geneva: E. Droz; 1957.

²²² Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SW, Mansourian PB, Davies AM, Piel A (Eds.). *Understanding the Global Dimensions of Health*. 15-33. New York: Springer; 2005.

²²³ Ascher CS. Problems in the World Health Organization’s Program. *International Organization*. 1952;6(1):27-50.

²²⁴ Siddiqi J. *World Health and World Politics: The World Health Organization and the UN System*. Columbus, South Carolina: University of South Carolina Press; 1995.

²²⁵ Porter D. The decline of social medicine in Britain in the 1960s. In Porter D. (Ed.). *Social Medicine and Medical Sociology in the Twentieth Century*. 97-113. Amsterdam-Atlanta, GA: Rodopi B.V.; 1997.

²²⁶ Goodman NM. *International Health Organizations and Their Work*. London: Churchill Livingston; 1971.

therapies cutting into the spread of infectious diseases under nascent national health services and with genetics providing a framework for considering health to be perceived as biologically (rather than socially) driven, public health systems began to lose relevance and were displaced by the medical profession's individual treatments.²²⁷ Combined with an understanding of hygiene and improvements in sanitary conditions, it was felt that infectious diseases could be controlled and would soon run their course within developed countries.²²⁸ As policy makers marveled at the imagined precipice of a world without disease, this medical model would be exported fervently to the developing world. Ignoring previously-recognized societal determinants of health,²²⁹ international development organizations—driven by the larger “medical-industrial complex” that had sprung from the Second World War²³⁰—imposed this biomedical vision of health on developing nations, emphasizing antibiotics, medical technologies, and private urban hospitals as a means to achieve economic growth.²³¹

WHO came to accept this medicalized consensus on health, whereupon it shifted away from the development of national health systems for underlying determinants of health and toward the provision of the individual medical treatments then thought to be

²²⁷ Taylor AL. Controlling the global spread of infectious diseases: Toward a reinforced role for the International Health Regulations. *Houston Law Review*. 1997;33:1327-1362.

²²⁸ Susser M. Ethical components in the definition of health. *International Journal of Health Services*. 1974;4:539-548.

²²⁹ Porter D. (Ed.). *Social Medicine and Medical Sociology in the Twentieth Century*. 97-113. Amsterdam-Atlanta, GA: Rodopi B.V.; 1997.

²³⁰ Ehrenreich B, Ehrenreich J. *The American Health Empire: Power, Profits and Politics*. New York: Vintage; 1970.

²³¹ Golub ES. *The Limits of Medicine: How Science Shapes Our Hope for the Cure*. Chicago: University of Chicago Press; 1994.

singularly necessary for achieving the highest attainable standard of health.²³²⁻²³³ Rather than working with states to develop comprehensive public health systems, the WHO Secretariat merely trained local health ministries in medical techniques, with the new Director-General viewing WHO personnel simply as a “catalyst,” “who, working on projects, pass on to their national counterparts the skill and knowledge needed to attack a specific health problem.”²³⁴ Based on the early success of WHO’s state coordination to combat yaws (a communicable disease characterized by swelling of the joints) through the dissemination of penicillin, WHO’s “yaws approach” sought medical solutions to individual, disease-specific ailments.²³⁵ Given the WHO view that medical technologies could lead to the complete eradication of various diseases, the World Health Assembly focused its attention on rationing the finite provision of medical supplies,²³⁶ rather than the sustainable policy frameworks of public health systems. Directed independently by autonomous regional offices, WHO’s technical assistance to national governments would focus on (1) advice in health services provision, (2) demonstrations of modern medical

²³² Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979.

²³³ Siddiqi J. *World Health and World Politics: The World Health Organization and the UN System*. Columbus, South Carolina: University of South Carolina Press; 1995.

²³⁴ Candau MG. World health catalysts. *American Journal of Public Health*. 1957;47(6):675-681. 676.

²³⁵ Peabody J. An organizational analysis of the World Health Organization: narrowing the gap between promise and performance. *Social Science and Medicine*. 1995;40(6):731-742.

²³⁶ E.g., World Health Assembly. Draft requirements for good manufacturing practice in the manufacture and quality control of drugs and pharmaceutical specialties. 1968.

practices, and (3) training of medical practitioners.²³⁷ Under such a framework for the practice of medicine, there was little room for the utilization of human rights to develop and implement social and legislative measures to realize underlying determinants of health.

Thus, with WHO taking a functional approach to health, it abandoned its efforts to develop and implement the right to health, as “[f]ulfilling its mandate was not done from a rights perspective nor with the aim of setting standards to be met by states.”²³⁸ Rather than setting rights-based goals, WHO framed disease, disability, and death merely as a strain on national “productive power” and a driver of “economic loss,”²³⁹ focusing on infectious disease eradication as a means to reach material ends. Where WHO had previously held up the UDHR’s declaration of a right to health as according with the Organization’s synoptic approach to underlying determinants of health, WHO would come to abrogate its relationship to health rights, finding the UDHR’s human rights obligations to involve “social questions” that were argued to be “beyond WHO’s competence.” When it came time for WHO to chronicle the first ten years of its own existence in 1958, no mention was made of its previous leadership in developing human rights norms or its previous cooperation with the Commission on Human Rights, emphasizing its cooperation with ECOSOC only in “activities having a direct bearing on

²³⁷ van Zile Hyde H. The nature of the World Health Organization. *Public Health Reports*. 1953;68(6):601-605.

²³⁸ Jamar SD. The international human right to health. *Southern University Law Review*. 1994;22:1-62:45.

²³⁹ Candau MG. WHO—prospects and opportunities: The road ahead. *American Journal of Public Health*. 1954;44(12):1499-1504. 1501.

certain public-health or medical questions of technical significance.”²⁴⁰ 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.”²⁴¹ People were in fact asking for health, but WHO had long neglected to construe it as a right, frustrating the advancement of human rights for the public’s health.

1. Human Rights Development – The International Treaty Framework Expands Without WHO

As the UN sought to expand its treaty framework for human rights—beginning with the transition from the UDHR to the ICESCR and then extending these rights outward to specific groups and elaborating these norms under specific rights—WHO eschewed the development of health rights under international law. Despite an understanding from the UN General Assembly that specialized agencies would take responsibility for creating detailed definitions of the human rights principles within their respective fields of action,²⁴² WHO did nothing to develop or clarify these broadly defined rights for health promotion. In the absence of WHO support for translating health discourses into health rights, the treaties developed during this era progressively weakened human rights norms for health. Given this WHO neglect, the right to health

²⁴⁰ World Health Organization. *The First Ten Years of the World Health Organization*. Geneva: World Health Organization; 1958: 59.

²⁴¹ World Health Organization. *The Second Ten Years of the World Health Organization*. Geneva: World Health Organization; 1968: ix.

²⁴² Samson KT. Human rights co-ordination within the UN system. In Alston P. *The United Nations and Human Rights: A Critical Appraisal*. 620-676. Oxford: Clarendon; 1992.

would be fatally weakened in creating state obligations to realize underlying determinants of health and would be rigidly set on a path from which it would never recover.

a. Economic, Social and Cultural Rights

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 the specialized agencies concerned for their observations during the final drafting process.²⁴³ In his September 1953 response, however, WHO's new Director-General responded with empty rhetoric, expressing appreciation for the correspondence but declining to make any observations, offering "I have no particular comment to offer on this report."²⁴⁴ Where other specialized agencies submitted long letters describing their final positions on relevant articles, WHO staff communicated simply by referring to technical documents, many of which had no bearing on human rights norms.²⁴⁵ Although specialized agencies were again asked to submit detailed comments on their reporting procedures for human rights implementation,²⁴⁶ WHO responded in December 1953 with far fewer comments relative to other agencies, requesting only that simpler reporting procedures be instituted, based

²⁴³ ECOSOC. Resolution 501 B (XVI). 3 Aug. 1953.

²⁴⁴ Letter from WHO Director-General M.G. Candau to UN Assistant Secretary-General Guillaume Georges-Picot. CC 4-6 ECOSOC (XVI). 22 Sept. 1953.

²⁴⁵ Commission on Human Rights. Tenth Session. Draft International Covenants on Human Rights and Measures of Implementation. Existing Procedures for Periodic Reporting to Specialized Agencies. E/CN.4/590/Add. 5. 9 Dec. 1953.

²⁴⁶ Letter from UN Assistant Secretary-General Georges-Picot to WHO Director-General M.G. Candau. SOA 317/1/01(2). 12 Oct. 1953.

on the notion that few states submit any reports to WHO for the WHO Secretariat to summarize for the Commission on Human Rights.²⁴⁷⁻²⁴⁸

After six sessions (1949-1954) devoted to transforming 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 moving to the General Assembly to review the language of these Covenants and over 12,000 pages of accompanying documentation.²⁴⁹⁻²⁵⁰ To prepare for this coming debate, the UN Secretary-General requested that the Division of Human Rights devote a full year to preparing an annotated summary of both draft covenants (then totaling 83 articles).²⁵¹ Developed in consultation with the specialized agencies, this systematic account, “The Draft International Covenants on Human Rights: An Annotation,” provided brief summaries of the debates on each article and laid out remaining questions for consideration by member states.²⁵²

²⁴⁷ Letter from WHO Director-General M.G. Candau to UN Assistant Secretary-General Georges-Picot. CC 4-6 HUMAN Rights OER. 9 Nov. 1953.

²⁴⁸ Commission on Human Rights. Tenth Session. Draft International Covenants on Human Rights and Measures of Implementation. Existing Procedures for Periodic Reporting to Specialized Agencies. E/CN.4/590/Add. 5. 9 Dec. 1953.

²⁴⁹ Memorandum from UN Division of Human Rights Acting Director Egon Schwelb to UN Department of Social Affairs Acting Principal Director John P. Humphrey. The Fate of the Draft Covenants on Human Rights. SOA 317/1/01. 11 Feb. 1954.

²⁵⁰ Memorandum from UN Division of Human Rights Acting Director Egon Schwelb to UN Assistant Secretary General Guillaume Georges-Picot and UN Department of Social Affairs Acting Principal Director John P. Humphrey. Draft Covenants on Human Rights. 23 Apr. 1954.

²⁵¹ United Nations General Assembly. Resolution 833 (IX).

²⁵² Annotations on the text of the draft International Covenants on Human Rights: prepared by the Secretary-General. A/2910 and Add. 1. 1955.

On the topic of the right to health, then article 13 of the draft Covenant on Economic, Social and Cultural Rights, the summary reflected WHO's early contributions to human rights development, 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.”²⁵³ Notwithstanding this praise for WHO's early leadership, the summary also reflected WHO's subsequent absence in human rights development, resurrecting disputes on the inclusion of (1) a definition of health, (2) the idea of “social well-being” and (3) the “steps to be taken” in the second paragraph. Although WHO was given the first six months of 1955 to review the UN's annotated summary,²⁵⁴ WHO never provided any comments, and the criticisms presented in the annotated summary were sent unaltered to the General Assembly.

As presented to the General Assembly, the final draft language on the right to health provided that:

1. 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.
2. 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:

²⁵³ Id.

²⁵⁴ Letter from WHO Director of Offices of External Relations and Technical Assistance to UN Under Secretary of the Department of Economic and Social Affairs. SOA 317/1/01(2). 18 Jan. 1955.

- (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.²⁵⁵

By the time the right to health moved to the Third Committee of the General Assembly in 1957, WHO had lost credibility to effect change within the UN or among state delegations. As delegates summarily eliminated the definition of health from the right to health—under the contradictory rationales that the definition was either unnecessarily verbose or irreconcilably incomplete—WHO made no attempt to prevent this deletion. Despite WHO’s previous argument that the definition accounted for underlying social determinants of health, a causal link that states had implicitly adopted through the WHO Constitution, state amendments prevailed in eliminating from paragraph 1 both the definition of health and any reference to “social well-being.”²⁵⁶ In addressing the “measures to be taken” in paragraph 2, additional changes to the language were made in:

- (1) the inclusion in 2(a) of “stillbirth;”

²⁵⁵ General Assembly Official Records. Annotations on the Text of the draft International Covenants on Human Rights. Prepared by the Secretary-General. A/2929. 1 July 1955.

²⁵⁶ A/C.3/L.589.

- (2) the substitution 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.”²⁵⁷

Abandoning its efforts to strengthen health rights, WHO took little part in these concluding debates relative to other specialized agencies.²⁵⁸ With debate on the right to health ending in a failed effort to place limitations on compulsory treatment, no amendments were offered to expand the obligations of this enfeebled right.²⁵⁹

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),²⁶⁰ thereafter renumbering the right from article 13 to article 12 but otherwise leaving the right to health largely how 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.

²⁵⁷ A/C.3/SR.746.

²⁵⁸ Social, humanitarian and cultural questions. *International Organization*. 1957;11(2):317-335.

²⁵⁹ United Nations General Assembly. Report of the Third Committee. UN Doc. A/3525. 9 Feb. 1957.

²⁶⁰ Memorandum from UN Division of Human Rights Director John P. Humphrey to UN Under-Secretary for Economic and Social Affairs Philippe de Seynes. 747th Meeting of the Third Committee. SO 221/9(1). 31 Jan. 1957.

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.

Although subsequent changes were made to other articles of the ICESCR—some in response to arguments from specialized agencies, such as FAO’s successful 1963 proposal that created article 11(2) on a right to food²⁶¹—WHO made no additional comments on the right to health, and UN delegates made no substantive changes to article 12.

As the UN moved from the substantive articles of the ICESCR to measures of implementation, the Commission on Human Rights again sought the opinions of specialized agencies, which would be expected to serve a crucial role as implementing agencies for the ICESCR.²⁶² Despite UN resolutions providing specialized agencies with

²⁶¹ Tomasevski K. *The Right to Food*. Dordrecht: Martinus Nijhoff Publishers; 1987.

²⁶² Schwelb E. Notes on the early legislative history of the measures of implementation of the human rights covenants. 270-289. In *Mélanges offerts à Polys Modinos: Problèmes des Droits de L'Homme et de L'Unification Européenne*. A. Pedone: Paris; 1968.

an official role in implementing the ICESCR,²⁶³ the only area in which WHO participated with the Commission on Human Rights was in reducing its reporting expectations under the right to health. Reflecting the limitations of WHO's International Digest of Health Legislation, this 1962 response did little more than update WHO's 1953 statement that each state "communicates promptly to the Organization important laws,"²⁶⁴ 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."²⁶⁵ In response to this—and in consideration of the significantly more robust responses from other specialized agencies (on clarifying norms, developing specific standards, promoting the realization of rights, and monitoring country performance)—the UN agreed that the UN Secretariat would pursue studies on the national legislation needed to implement human rights at the national level and that states would report directly to ECOSOC on the measures adopted and progress made in achieving observance of the rights.²⁶⁶ Although the ICESCR additionally provided specialized agency authority to submit reports on the progressive implementation of the Covenant, well over a decade of reports by other specialized agencies would pass before WHO

²⁶³ United Nations General Assembly. Resolution 926 (X). 1956.

²⁶⁴ Letter for WHO Deputy Director-General P. Dorolle to UN Chef de Cabinet C.V. Narasimhan. 7 Aug. 1962.

²⁶⁵ United Nations General Assembly. Seventeenth Session. Third Committee. Agenda Item 43. Draft International Covenants on Human Rights. Existing Procedures for Periodic Reporting to Specialized Agencies. Note by the Secretary General. A/C.3/L.1015. 31 Oct. 1962 (emphasis added).

²⁶⁶ UN General Assembly. Resolution 2106A(XX). 21 Dec. 1965.

submitted its first report;²⁶⁷ although the ICESCR provided UN authority to submit ECOSOC reports to specialized agencies on issues that fall within the agencies' respective field of competence,²⁶⁸ the UN sent no state 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,"²⁶⁹ WHO made no specific commitments and took no programmatic action to implement the health rights codified in the ICESCR.

Once the ICESCR was adopted and opened for signature in December 1966,²⁷⁰ WHO claimed no ownership over the new Covenant's obligations on health, noting in its records that:

In response to a question from Mr. Schreiber [Director, UN 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

²⁶⁷ Trubek DM. Economic, social, and cultural rights in the Third World: Human rights law and human needs programs. In Meron T. *Human Rights in International Law: Legal and Policy Issues*. Clarendon: Oxford. 1984. 205-272.

²⁶⁸ International Covenant on Economic, Social and Cultural Rights. United Nations General Assembly. Resolution 2200A (XXI). 16 Dec. 1966. art. 40, ¶3.

²⁶⁹ Alston P. The United Nations' specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights, *Columbia Journal of Transnational Law*. 1979;18:79-118: 117.

²⁷⁰ International Covenant on Economic, Social and Cultural Rights. United Nations General Assembly. Resolution 2200A (XXI). 16 Dec. 1966.

terms and WHO could not press its Member States with respect to the covenants.²⁷¹

With states moving independently to ratify the ICESCR, translating its international obligations into national legislation and national legislation into governmental health policy, WHO was silent on its role in developing, promoting, and implementing the right to health. As the years passed, WHO's continued neglect for health rights eliminated public health advocates' opportunities to elaborate the scope and content of health rights in accordance with public health discourse, leaving article 12's imprecise elaboration of the right to health as the seminal, final, and definitive international legal obligation pursuant to this right.

b. Rights of the Child

In 1959 debates on a draft Declaration of the Rights of the Child, although the UN Secretariat welcomed WHO amendments in the drafting process, the WHO representative to Commission on Human Rights received instructions from the office of the Director-General to offer only general support,²⁷² leading the representative not to make any statement or offer public comments.²⁷³ Similarly, when the UN in 1963 considered an article on the rights of the child for the International Covenants on Human Rights, WHO's Director-General declined to respond substantively to the call for comments from

²⁷¹ WHO. Notes for the Record. Meeting with Mr. Marc Schreiber, Director, United Nations Division of Human Rights – Friday, 5 May 1972. 4N64/372/1. 29 May 1972.

²⁷² Memorandum from PHA Section to WHO Assistant Director-General P.M. Kaul. Human Rights Commission, 15th Session, Right of the Child. 28 Jan. 1959.

²⁷³ Memorandum from WHO Director, Liaison Office with United Nations to WHO Deputy-Director General. Report on the Fifteenth Session of the Commission on Human Rights. 21 Apr. 1959.

specialized agencies, noting the language of the WHO Constitution but thereafter denying any involvement in issues impacting the rights of the child:

The directing organs of WHO have, however, taken no decision that apply directly to the proposals considered by the General Assembly before adopting resolution 1843A(XVII) [article on the rights of the child]. It is for the General Assembly to decide, on the advice of *the competent United Nations organs*, whether it is desirable to add to the draft convention an article on the rights of the child; on that question, therefore, I have no comments to offer.²⁷⁴

In the wake of this statement, it was decided that WHO would make no further comments on the health rights of children and would not attend subsequent discussions on the rights of the child.

c. Discrimination Against Women

In December 1963, the UN General Assembly, based on the work of the Commission on the Status of Women, began work on a draft Declaration on the Elimination of Discrimination against Women, seeking for the first time to address discrimination against women in a comprehensive manner.²⁷⁵ While WHO recognized that discrimination against women had an impact on health, it saw its role as confined to dealing with the effects of discrimination in medical care, not with the discrimination itself, with the WHO legal office interpreting the “non-discrimination clause” in the

²⁷⁴ Letter from WHO Director-General M.G. Candau to UN Chef de Cabinet C.V. Narasimhan. N64/86/2(17). 8 Feb. 1963 (emphasis added).

²⁷⁵ United Nations General Assembly. Resolution 1921 (XVIII). 5 Dec. 1963.

Preamble of the WHO Constitution not to refer to discrimination on account of sex.²⁷⁶

As a result, WHO responded to the UN Division of Human Rights in February 1964 that because “WHO is not entrusted with responsibility for direct action to overcome such [discriminatory] restrictions,” it was “not possible to derive from the work of WHO principles that might be incorporated into a draft declaration.”²⁷⁷ Although WHO continued to provide technical consultation to the UN Programme for the Advancement of Women—reproducing (1) WHO technical reports on the Day Care Centres for Children and the Care of Well Children in Day Care Centres and Institutions and (2) WHO seminar reports under the Programme of Advisory Services for Human Rights²⁷⁸⁻²⁷⁹—it produced no new reports for the Commission on the Status of Women during the 1965-1967 drafting process.²⁸⁰

Adopted by the UN General Assembly in November 1967, the resulting Declaration on the Elimination of Discrimination Against Women²⁸¹ covers a wide range of areas relating to gender equality in underlying determinants of health – reflecting areas

²⁷⁶ Memorandum from LEG Director F. Gutteridge to P. Dorolle. Discrimination Against Women. 12 Feb. 1964.

²⁷⁷ Letter from WHO Deputy-Director P. Dorolle to UN Division of Human Rights Director John P. Humphrey. N64/180/5(2). 17 Feb. 1964.

²⁷⁸ Letter from WHO Assistant Director-General L. Bernard to UN Division of Human Rights Director M. Schreiber. SO 244 (11). 19 Dec. 1966.

²⁷⁹ Memorandum from WHO Chief, HR A. Kessler to WHO Director-General M.G. Candau. Meetings on the Commission on the Status of Women. N64/180/5(a). 3 Dec. 1968.

²⁸⁰ ECOSOC. Commission on the Status of Women. United Nations Assistance for the Advancement of Women. E/CN.6/478. 6 Feb. 1967.

²⁸¹ United Nations General Assembly. Resolution 2263 (XXII). 7 Nov. 1967.

of specialized agency contribution on, among other things, article 6 on the rights of the girl child (reflecting contributions from UNICEF), article 9 on rights to education (reflecting contributions from UNESCO) and article 10 on right to employment (reflecting contributions of ILO). However, given WHO reluctance to contribute to this process, the Declaration does not address health rights or a woman's right to health. While the Declaration recognizes "that discrimination against women is incompatible with human dignity and with the welfare of the family and of society, prevents their participation, on equal terms with men, in the political, social, economic and cultural life of their countries and is an obstacle to the full development of the potentialities of women in the service of their countries and of humanity," it discusses neither gender discrimination in health nor the effects of gender discrimination on underlying determinants of health.

Following the promulgation of the Declaration, ECOSOC directed specialized agencies in March 1968 to take specific steps to publicize the declaration, to bring it to the attention of member states, and to undertake studies on the role of women "in a changing world."²⁸² WHO, finding itself under pressure from women's advocates to go beyond its previous "pro-forma statements," sought initially to focus on discrimination against women as impinging on underlying determinants of health, although after surveying its divisions for comment in 1968, the Chief of WHO's Office of Programme Co-ordination decided that WHO's focus would remain confined to discrimination against women in entering the medical profession and obtaining medical and nursing

²⁸² ECOSOC. Resolution 1325 (XLIV). 31 Mar. 1968.

education.²⁸³⁻²⁸⁴ After additional internal debate—contemplating additional studies on “the importance of social factors – including discrimination against women – in maternal...perinatal and infant mortality and morbidity”—WHO backed away from even this limited focus, deciding in 1970 simply to bring the UN General Assembly’s resolution to the attention of the World Health Assembly but taking no further steps to implement the Declaration for women’s health.²⁸⁵

d. Racial Discrimination

To advance racial justice through human rights, the Commission on Human Rights’ Sub-Commission on the Prevention of Discrimination and the Protection of Minorities began work in the 1950s to initiate human rights studies, organize human rights seminars, and work with specialized agencies to develop human rights treaties.²⁸⁶ With the cooperation and support of several UN specialized agencies, the Sub-Commission:

- requested a study on discrimination in employment and occupation from the ILO, which reported to the Sub-Commission in 1957 and then used the Sub-

²⁸³ Memorandum from WHO Chief, PC Sacks to WHO Director, CE Bellerive and WHO Assistant Director-General L. Bernard. Implementation of the Declaration on the Elimination of Discrimination Against Women. N64/180/5 (A). 21 June 1968.

²⁸⁴ Memorandum from WHO Assistant Director-General L. Bernard to WHO Chief, PC Sacks. ECOSOC Resolution 1325 (XLIV) – Declaration on the Implementation of the Elimination of Discrimination Against Women. N64/180/5 (A). 31 July 1968.

²⁸⁵ Memorandum from WHO Chief, PC Sacks to WHO Maternal and Child Health Director. Implementation of the Declaration on the Elimination of Discrimination Against Women. 10 Aug. 1970.

²⁸⁶ Humphrey JP. The United Nations Sub-Commission on the Prevention of Discrimination and the Protection of Minorities. *American Journal of International Law*. 1968;62:869-888.

Commission's comments and recommendations in adopting the ILO's 1958 Convention Concerning Discrimination in Respect of Employment and Occupation,²⁸⁷

- appointed a Special Rapporteur on discrimination in education, whose 1957 study²⁸⁸ formed the basis of UNESCO's 1960 Convention Against Discrimination in Education,²⁸⁹ and
- appointed a Special Rapporteur on Slavery,²⁹⁰ whose 1966 report on the continued existence of a global slave trade²⁹¹ led the way to the UN Division of Human Rights' 1967 report on resources in the United Nations system to eliminate all vestiges of slavery and slavery-like practices of apartheid and colonialism²⁹² and ECOSOC's 1968 resolution to broaden the mandate of the Sub-Commission on the Prevention of Discrimination and Protection of Minorities to address legal measures for the abolishing slavery.²⁹³

²⁸⁷ ILO Convention (No. 111) Concerning Discrimination in Respect of Employment and Occupation, adopted 25 June 1958. 362 UN Treaty Series 31.

²⁸⁸ Study of Discrimination in Education, by Charles D. Ammoun, Special Rapporteur of the Sub-Commission on the Prevention of Discrimination and the Protection of Minorities. UN Doc. E/CN.4/Sub.2/181/Rev.1. 1957.

²⁸⁹ UNESCO Convention Against Discrimination in Education. 14 Dec. 1960. 429 UN Treaty Series 93.

²⁹⁰ ECOSOC. Slavery. Res. 960 (XXXVI). 12 July 1963.

²⁹¹ Awad M. *Report on Slavery*. United Nations publication, Sales No. 67.XIV.2.

²⁹² Report of the Secretary-General on Technical Assistance to Eliminate Vestiges of Slavery. 15 Aug. 1967

²⁹³ ECOSOC Res. 1330 (XLIV). May 1968.

While the Sub-Commission would initiate a series of studies in the following decade,²⁹⁴ it neither conducted a study nor appointed a Special Rapporteur to investigate racial discrimination in health, as the WHO Secretariat during this period repeatedly found racial discrimination, slavery, and apartheid to be “outside the competence of the World Health Organization.”²⁹⁵

Once the UN General Assembly had adopted the 1963 Declaration on the Elimination of All Forms of Racial Discrimination,²⁹⁶ specifically requesting specialized agencies to “ensure the immediate and large-scale circulation of the Declaration,”²⁹⁷ WHO responded simply by including the Declaration as an annex to the Director-General’s report to the Executive Board on “Decisions of the United Nations, Specialized Agencies and the International Atomic Energy Agency Affecting WHO’s Activities.”²⁹⁸ In subsequent requests to update the UN General Assembly on actions taken by the specialized agencies, with the UN Secretariat seeking to assist states in drafting a Convention on the Elimination of All Forms of Racial Discrimination, WHO belatedly responded in December 1965 to note simply that while legislation is outside its

²⁹⁴ Humphrey JP. The United Nations Sub-Commission on the Prevention of Discrimination and the Protection of Minorities. *American Journal of International Law.* 1968;62:869-888.

²⁹⁵ E.g., Letter from WHO Programme Co-ordination Chief Michael R. Sacks to UN Division of Human Rights Director John P. Humphrey. 4N64/372/1. 14 Oct. 1964.

²⁹⁶ UN General Assembly. Resolution 1904 (XVIII). United Nations Declaration on the Elimination of All Forms of Racial Discrimination. 1963.

²⁹⁷ Letter from UN Under-Secretary for Public Information H. Tavares do Sá to WHO Director General Marcolina G. Candau. 28 Feb. 1964.

²⁹⁸ Letter for WHO Deputy-Director P. Dorolle to UN Under-Secretary for Public Information H. Tavares do Sá. 7 Apr. 1964.

competence, its technical programs “may be said to give effect to the principle of non-discrimination,” blithely submitting a supplementary report on “Publicity to be given to UN Declaration on the Elimination of All Forms of Racial Discrimination”:

In line with the general policy of WHO, the anti-discriminatory approach to all matters is followed implicitly rather than explicitly. Such a method has always been considered more effective. . . . [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.²⁹⁹

Five days later, without WHO input, the UN General Assembly adopted the 1965 International Convention on the Elimination of All Forms of Racial Discrimination (CERD).³⁰⁰ Despite implementation mechanisms far stronger than the initial implementation mechanisms of the ICCPR and ICESCR, CERD did not expand health rights beyond that developed in the ICESCR, making it of little use to those advocating against discrimination in medical care and underlying determinants of health. With health discrimination and inequities in health care taken up by nongovernmental organizations—forming a contemporaneous impetus for Martin Luther King’s invocation, “of all the forms of inequality, injustice in health care is the most shocking

²⁹⁹ Letter from WHO Assistant Director-General L. Bernard to UN Director of the Division of Human Rights John P. Humphrey. 16 Dec. 1965.

³⁰⁰ United Nations General Assembly. International Convention on the Elimination of All Forms of Racial Discrimination. Res. 2106A(XX). 21 Dec. 1965.

and inhumane”—these pressing civil rights struggles would not be a part of the international human rights debate. Following CERD’s 1969 entry into force, with the ILO and UNESCO offering extensive cooperation to the Committee on the Elimination of Racial Discrimination, only these specialized agencies would attend Committee hearings, addressing issues of discrimination only in employment and education.³⁰¹

This WHO neglect of racial discrimination would extend to subsequent efforts to implement CERD to address underlying determinants of health. As the Sub-Commission on the Prevention of Discrimination and the Protection of Minorities followed up on CERD by appointing a Special Rapporteur in 1966 to study broadly the issue of racial discrimination in the political, economic, social, and cultural fields,³⁰² WHO did not cooperate with the Special Rapporteur—repeating its disclaimer of competence on such issues³⁰³—and the Special Rapporteur’s resulting study does not address discrimination in health.³⁰⁴ When the UN requested a 1966 update on measures taken to implement the earlier Declaration on the Elimination of All Forms of Racial Discrimination,³⁰⁵ WHO

³⁰¹ Samson KT. Human rights co-ordination within the UN system. In Alston P. *The United Nations and Human Rights: A Critical Appraisal*. 620-676. Oxford: Clarendon; 1992.

³⁰² ECOSOC. Resolution 1076 (XXXIX).

³⁰³ Letter from WHO Assistant Director-General L. Bernard to UN Division of Human Rights Director John P. Humphrey. 4N64/372/1. 31 Mar. 1966.

³⁰⁴ Hernán Santa Cruz. Special Study of Racial Discrimination in the Political, Economic, Social and Cultural Spheres, 17 Nov. 1966. UN Doc. E/CN.4/Sub.2/267.

³⁰⁵ Letter from UN Director of the Division of Human Rights Marc Schreiber to WHO Director-General Marcolino G. Candau. 11 Oct. 1966.

responded that it had nothing to add.³⁰⁶ With the UN's 1969 reappointment of the Special Rapporteur on Slavery—specifically requesting that the specialized agencies cooperate in his study on slavery and apartheid³⁰⁷⁻³⁰⁸—WHO again declined to cooperate in his report. Although WHO program staff had wanted to assist in the health components of this Special Rapporteur study,³⁰⁹ their decisions were overruled by WHO's Coordination Chief, who contradicted program staff in noting that “[i]t seems rather unlikely that WHO has information directly relevant to the Special Rapporteur's study”³¹⁰ and leading health determinants to be ignored in the resulting report on slavery.³¹¹

As the UN General Assembly sought to follow-up the UN's 1971 International Year for the Elimination of Racial Discrimination with a decade-long UN initiative on racial discrimination, WHO questioned the applicability of health to these rights-based discourses, noting that “it was not the feeling of WHO that a segmental [race-based] approach would be useful as[,] in the field of health[,] access to services and availability

³⁰⁶ Letter from WHO Assistant Director-General L. Bernard to UN Director of the Division of Human Rights Marc Schreiber. 1 Nov. 1966.

³⁰⁷ ECOSOC. Resolution 1419 (XLVI). 10 Sept. 1969.

³⁰⁸ Letter from UN Division of Human Rights Deputy Director Edward Lawson to WHO Director-General Marcolino G. Candau. SO 252/1 (4). 29 Jan. 1970.

³⁰⁹ Memorandum from WHO EK to WHO Programme Co-ordination Chief Michael R. Sacks. Request of Mr. Awad, Special Rapporteur, Subcommission on Prevention of Discrimination and Protection of Minorities. 4N64/372/1. 20 Feb. 1970.

³¹⁰ Letter from WHO Programme Co-ordination Chief Michael R. Sacks to UN Division of Human Rights Deputy Director Edward Lawson. 4N64/372/1. 25 Feb. 1970.

³¹¹ Lassen N. Slavery and slavery-like practices: United Nations standards and implementation. *Nordic Journal of International Law*. 1988;57(2):197-227.

of services was more related to general economic levels or to urban-rural differences in facilities.”³¹² Despite a request for specialized agency statements as part of the Commission on Human Rights’ approach to the Decade for Action to Combat Racism and Racial Discrimination (to be launched in 1973),³¹³ WHO made no statement and suggested no proposals. In doing so, WHO first reiterated the position that “WHO does not consider a sectoral [race-based] approach to this problem as particularly appropriate or relevant”³¹⁴ and based upon this, subsequently suggested that the Commission on Human Rights formally limit its consultation only to “appropriate” specialized agencies.³¹⁵ Initial activities under the UN’s Programme would bear this out,³¹⁶ with health discourse falling out of UN human rights planning for the Decade for Action to Combat Racism and Racial Discrimination.

³¹² WHO Notes for the Record. Meeting with Mr. Marc Schreiber, Director, United Nations Division of Human Rights – Friday, 5 May 1972. 4N64/372/1. 29 May 1972.

³¹³ UNGA Res. 2919, U.N. GAOR, 27th Sess., 2085th plen. mtg. 1972.

³¹⁴ Letter from WHO Division of Co-ordination Director A. Bellerive to UN Division of Human Rights Director Marc Schreiber. 4N64/372/1. 27 June 1972.

³¹⁵ Letter from WHO Programme Co-ordination Chief Michael R. Sacks to UN Division of Human Rights Deputy Director Edward Lawson. 4N64/372/1. 14 July 1972.

³¹⁶ Decade for Action to Combat Racism and Racial Discrimination, G.A. Res. 3057, U.N. GAOR, 28th Sess., at 102, 1973. Reprinted in United Nations. World Conference to Combat Racism and Racial Discrimination, 2d, Geneva, 1-12 August 1983. Compilation of United Nations Resolutions and Decisions Relevant to the Struggle against Racism, Racial Discrimination and Apartheid. Geneva: UN, 1983. A/CONF.119/15.

2. Human Rights Implementation – WHO Abandons Its Human Rights Mission

This WHO neglect for human rights frameworks would extend from the development of health rights to the implementation of health rights, with WHO hindering state realization of the right to health through its limited and constrained participation in UN human rights advisory services and seminars, reporting to the Commission on Human Rights, human rights awareness-raising activities, and inter-agency studies on human rights.

a. Advisory Services

Beginning in 1956 under a UN General Assembly resolution to create a broad programme of assistance in the field of human rights,³¹⁷ the Commission on Human Rights began its longstanding work to operationalize human rights through (a) advisory services by prominent human rights experts, (b) fellowships and scholarships, and (c) regional human rights seminars.³¹⁸ Under this last initiative, governments and specialized agencies conducted a series of seminars to share experiences in implementing international legal standards for human rights³¹⁹ and “to bring key people together for short periods of time to stimulate their thinking and through their leadership to encourage

³¹⁷ United Nations General Assembly. Resolution 926 (X). 14 Dec. 1955.

³¹⁸ ECOSOC. Resolution 605 (XXI). Advisory Services in the Field of Human Rights. 3 May 1956.

³¹⁹ Humphrey JP. Human rights: New directions in the U.N. program. *New York Law School Law Review*. 1958;391-397.

greater awareness of problems of human rights within official circles.”³²⁰ In doing so, these UN seminars would, as described by the Director of the UN Division of Human Rights, “help to create a climate of opinion favourable to human rights and also keep alive the discussion of fundamental issues.”³²¹ However, when the Commission on Human Rights specifically reached out to specialized agencies to identify human rights implementation issues for these seminars, Director-General Candau dismissed these requests and 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,”³²² setting the stage for WHO’s limited participation in human rights seminars.

While these seminars helped to advance the implementation of human rights standards and the development of new human rights norms, health rights suffered where WHO took an extremely limited role in their creation, organization, and instruction, declining all invitations to lead these seminars and participating in only the few seminars discussed below:

In August 1964, WHO sent a representative to the United Nations Seminar on the Status of Women in Family Law in Lome, Togo. Based upon discussion on female circumcision at the UN Seminar on the Participation of Women in Public Life in Addis Ababa in 1960 (which WHO did not attend) and concerned

³²⁰ Statement Made by the Secretary-General on Advisory Services in the Field of Human Rights at the Twelfth Session of the Commission on Human Rights. E/CN.4/L.416. 1956.

³²¹ Humphrey JP. Human rights: New directions in the U.N. program. *New York Law School Law Review*. 1958;391-397: 395.

³²² Letter from WHO Director-General Candau to UN Secretary-General Thant. 27 Feb. 1956.

that the issue would be raised anew, WHO sought to reiterate its 1961 statement to the Commission on the Status of Women that “ritual operations...are based on social and cultural backgrounds, the study of which is outside the competence of the World Health Organization.”³²³ Although WHO sent an “observer” from the African Regional Office to this seminar, that representative received confidential instructions from Secretariat headquarters that “[u]nder no circumstances should [s]he engage in the discussion of medical matters, as these would be out of order.”³²⁴ In lieu of participation in these rights-based discussions, WHO’s representative merely read a written statement from the Secretariat indicating that “operations based on customs” are deeply rooted in tradition and thus require social change – social change that was argued to fall outside the competence of WHO.³²⁵

In 1966, WHO was pressed by the UN Division of Human Rights to create a briefing for the United Nations Regional Seminar on Human Rights in Developing Countries for African countries in Dakar, Senegal. Based on a May 1964 United National Seminar on Human Rights in Developing Countries for South East Asian countries in Kabul (which the WHO representative in

³²³ World Health Organization. Statement. Commission on the Status of Women. Mar. 1961.

³²⁴ Memorandum from WHO Deputy-General P. Dorolle to PR-DG, AFRO. UN Seminar on the Status of Women in Family Law – Lome, Togo, 18-31 August 1964. 30 June 1964.

³²⁵ Laura H. Yergan. Remarks Made at the United Nations Seminar on the Status of Women in Family Law. 28 Aug. 1964.

Afghanistan attended without approval from Secretariat headquarters),³²⁶ WHO suggested that the African Regional Office select a representative, providing him with a detailed memorandum on human rights treaty language regarding health and WHO's contributions on the issue of health planning.³²⁷ With this Headquarters memorandum reiterating WHO's 1957 position that the Organization was not "entrusted with safeguarding legal rights," it included samples of WHO's statements from previous seminars in Kabul and Lome, on which WHO's Dakar statement was wholly drawn without any original statement on human rights.³²⁸

In 1967, WHO sent a representative from its Health Education Division to the far larger UN Human Rights Seminar in Warsaw, Poland. With representatives from throughout the world seeking to deal comprehensively with the realization of economic and social rights in the UDHR, the UN Division of Human Rights reached out to WHO in February 1966 for suggested agenda topics related to health rights.³²⁹ Although the WHO Secretariat reluctantly agreed to attend this seminar, WHO's response to the UN questioned the very premise of its involvement in a seminar on the UDHR, advancing for the first time the reasoning

³²⁶ Memorandum from WHO SEARO Regional Director to WHO Headquarters. Seminar on Human Rights in Developing Countries, Kabul – 12 to 25 May 1964. 9 July 1964.

³²⁷ Memorandum from WHO Assistant Director-General L. Bernard to WHO Regional Director, AFRO. UN Seminar on Human Rights in Developing Countries for Participants from African Countries – Dakar – 8-22 February 1966. 23 Sept. 1965.

³²⁸ Draft Report. United Nations Seminar on Human Rights in Developing Countries. Dakar, Senegal. 8-22 Feb. 1966.

³²⁹ Letter from UN Deputy Director, Division of Human Rights Edward Lawson to WHO Director-General M.G. Candau. SO 216/3. 17 Feb. 1966.

that implementation of the UDHR was entirely beyond WHO's competence, as "Article 25 of the Declaration mentions health only in connection with the standard of living and – implicitly – in the reference to womanhood and childhood."³³⁰ To the extent that WHO would participate in this seminar, it would do so only based upon the inclusion of health as a human right in the Constitution of WHO and Draft Covenant on Economic, Social and Cultural Rights. During the course of this expansive August 15-28, 1967 seminar, with twenty-five country representatives and twenty-eight papers (including those of WHO, ILO, and UNESCO),³³¹ the WHO representative presented WHO's paper, "Provision of Appropriate Health Protection to the Community," which briefly outlined that:

- Health is a fundamental human right, based in international law and national constitutions, and upon which WHO has based its work under a positive definition of health;
- Health is necessary for economic development, and thus investment in health is necessary to raise living and working conditions;
- Realization of the right to health is a responsibility of governments, although emerging countries may require international collaboration and assistance; and

³³⁰ Letter from WHO Assistant Director-General L. Bernard to UN Deputy Director, Division of Human Rights Edward Lawson. SO 216/3. 18 July 1966.

³³¹ Seminar on the realization of economic and social rights contained in the Universal Declaration of Human Rights. Warsaw, Poland, 15-28 August 1967. Organized by the United Nations in co-operation with the Government of Poland. ST/TAO/HR/31. New York: United Nations. 1967.

- Provision of health services differs based upon the financial situation and resources allocation of a country (distinguishing examples of governmental health administration, compulsory insurance schemes, and privately arranged medical care);

and explained in vastly greater detail on underlying determinants of health that:

- A health programme must provide facilities that are widely available to the population and include basic health services for “health protection to the community”—including maternal and child health care, nutrition, communicable diseases control, environmental sanitation, health education, mental health, and occupational health services.³³²

The WHO representative presented this paper along with a dramatic presentation, observing that “health is the infrastructure without which other rights have little meaning” and concluding, after reviewing the elements of health services, that “it seems technically possible for all European governments to recognize the right of their peoples to health protection of a reasonably high order and to provide the conditions which make a healthy life possible.”³³³ Although the WHO representative did not take part in the ensuing debate on the provision of

³³² United Nations. United Nations Seminar on the Realization of Economic and Social Rights Contained in the Universal Declaration of Human Rights. Paper Prepared by the World Health Organization. SO 216/3 (12) EUR 1967.

³³³ WHO Representative John Burton. Report on Duty Travel. UN Seminar on the Realization of Economic and Social Rights Contained in the Universal Declaration of Human Rights. Warsaw, Poland. 15-28 Aug. 1967.

appropriate health protection, his presentation nevertheless elevated health in the human rights debate, with delegates concluding both that “medical services should be available free to all” and that “the basic health law of a country should cover: maternal and child health care, nutrition, communicable diseases [sic] control, environmental sanitation, health education, mental health and occupation health services.”³³⁴ Without WHO advice to further this health discussion in the seminar’s debate on the prioritization of elements of social policy, however, states would have little opportunity to advance human rights obligations for underlying determinants of health.

Notwithstanding this fleeting human rights initiative in Warsaw, WHO did not thereafter attempt to engage in larger issues of human rights advancement for health. Even when the time came to develop regional seminars based on the Warsaw seminar, WHO’s representative to the 1969 United Nations Seminar on the Realization of Economic and Social Rights with Particular Reference to Developing Countries in Nicosia, Cyprus did not focus on human rights, emphasizing in his remarks the dependence of economic development on the health of the population,³³⁵ echoing the WHO Director-General’s framing that “without health, development has no hope of

³³⁴ Seminar on the realization of economic and social rights contained in the Universal Declaration of Human Rights. Warsaw, Poland, 15-28 August 1967. Organized by the United Nations in co-operation with the Government of Poland. ST/TAO/HR/31. New York: United Nations. 1967. ¶ 71.

³³⁵ Seminar on Special Problems Relating to Human Rights in Developing Countries, Nicosia, Cyprus. 26 June – 9 July 1969. UN Doc. ST/TAO/HR/36. New York: United Nations. 1970.

putting down its roots.”³³⁶ WHO did not send a representative to the corresponding 1970 African seminar in Kitwe, Zambia.³³⁷ Given WHO’s limited involvement in UN human rights seminars and lack of communication with the UN Division of Human Rights, decades would pass before there would be a human rights seminar on the relationship between human rights and health.

b. Reporting

In the midst of WHO’s abdication of leadership in UN efforts to assist states in implementing international human rights norms, WHO also began a coordinated campaign to distance itself from any implementation responsibilities to the UN, shirking and then disclaiming its responsibilities to ECOSOC to report on health rights for the Commission on Human Rights and to review state reports under human rights treaties.

Beginning in 1956, ECOSOC directed specialized agencies to submit periodic reports on both the human rights activities of the specialized agency and the progress of member states in realizing rights within their organizational purview.³³⁸ While there was little enthusiasm among the WHO leadership for this human rights reporting (for which WHO had no assigned personnel or budget), WHO was concerned that because it “co-operated with the Human Rights Commission in preparing the draft Covenant on Human

³³⁶ World Health Organization. *The Second Ten Years of the World Health Organization*. World Health Organization: Geneva. 1968; ix.

³³⁷ Seminar on the Realization of Economic and Social Rights with Particular Reference to Developing Countries, Lusaka, Zambia, 23 June - 4 July 1970. Organized by the United Nations Division of Human Rights in co-operation with the Government of Zambia. Zambia: United Nations Division of Human Rights. 1970.

³³⁸ ECOSOC. Resolution 624B(XXII). Periodic reports on human Rights and studies of specific rights or groups of rights. 1 Aug. 1956.

Rights, its failure to act under the Resolution on Annual Reports might be interpreted as obstructive.”³³⁹ Although the UN had previously pressed for a coordinated approach to international action in economic and social policy, WHO’s failure to respond to those UN requests had led the UN Secretary-General to ignore WHO activities in his June 1956 enumeration of human rights coordination among specialized agencies.³⁴⁰ (WHO had further damaged its human rights standing by responding to ECOSOC’s September 1956 request for contributions to the UN’s Yearbook on Human Rights³⁴¹ by noting that “the information which WHO could provide on this subject would not be suitable for inclusion in the Yearbook, as it [WHO] deals with health not in the light of human rights but as a technical subject.”³⁴²) After a series of admonitions from the UN Secretariat, the WHO Secretariat came to believe in late 1956 that the Organization was under an unavoidable obligation to submit human rights reports, whereupon they sought to assess the implications of these UN periodic reports to its work in public health, to examine the detailed reporting procedures of ILO and UNESCO, and to gauge the extent to which information from member states’ “technical” reports could be translated and summarized

³³⁹ Memorandum from WHO Liaison B. Howell to WHO Assistant Director-General P.M. Kaul. Human Rights Commission 12th Session Resolution on Annual Reports. 23 Apr. 1956.

³⁴⁰ ECOSOC. General Review of the Development and Co-ordination of the Economic, Social and Human Rights Programmes and Activities of the United Nations and the Specialized Agencies as a Whole. Introductory Statement by the Secretary General. Twenty-Second Session. E/2894/Rev.1. 14 June 1956.

³⁴¹ Letter from UN Deputy Under-Secretary for Economic and Social Affairs Martin Hill to WHO Director-General Marcolino Gomes Candau. 13 Sept. 1956.

³⁴² Letter from WHO Director of the Division of External Relations and Technical Assistance P.M. Kaul to UN Deputy Under-Secretary for Economic and Social Affairs Martin Hill. 26 Sept. 1956.

into a WHO “legal” report on article 25 of the UDHR. However, despite this extended consideration of human rights reporting by WHO staff, Director-General Candau rejected this responsibility for human rights reporting, responding to the UN Secretariat in February 1957 simply to announce 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.”³⁴³

The UN Secretariat—in the process of finalizing its appraisal of economic, social and human rights coordination among specialized agencies for the Commission on Human Rights³⁴⁴⁻³⁴⁵—took great exception to WHO’s organizational obstreperousness toward ECOSOC and programmatic dereliction toward human rights for health. To allay this breach in UN relations, the UN Deputy Under-Secretary for Economic and Social Affairs first wrote a conciliatory letter to the WHO Director-General in March 1957 to encourage WHO’s further participation in the human rights endeavor, requesting only a “very brief summary” of human rights activities (with reference to both article 25 of the UDHR and article 13 of the draft Covenant on Economic, Social and Cultural Rights) and extending the deadline for WHO’s submission of that summary.³⁴⁶ When that failed—with WHO’s Deputy Director-General reiterating the Organization’s decision not to

³⁴³ Letter from WHO Director-General M.G. Candau to UN Deputy Under-Secretary for Economic and Social Affairs Martin Hill. SOA 317/15/01(2). 19 Feb. 1957.

³⁴⁴ ECOSOC. Resolution 665A(XXIV). 1957.

³⁴⁵ United Nations. *Five-Year Perspective 1960-64: Consolidated Report on the Scope, Trend and Costs of the Programmes of the UN, ILO, FAO, UNESCO, WHO, WMO and IAEA in the Economic, Social and Human Rights Fields*. E3347/Rev.1. 1960.

³⁴⁶ Letter from UN Deputy Under-Secretary for Economic and Social Affairs Martin Hill to WHO Director-General M.G. Candau. SO 214 (2-1-2). 22 Mar. 1957.

submit any report or position on human rights³⁴⁷—the UN Secretariat abandoned its effort to obtain compliance from WHO in human rights reporting, forwarding all WHO communications to the Commission on Human Rights.

When the Commission on Human Rights met in 1958 to review country and specialized agency reports, the Commission members, while commending other specialized agencies for their work on these reports, took strenuous objection to WHO's statements.³⁴⁸ In particular, the French Representative, Rene Cassin (a progenitor of the UDHR who would later be awarded the Nobel Peace Prize for his human rights work), expressed his personal disappointment with WHO and sought to impress upon the WHO representative that he had an unassailable duty to report on WHO's activities, suggesting a litany of reports on a range of topics: (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.³⁴⁹ Relenting in the face of this institutional opprobrium, the WHO representative affirmed that WHO would soon transmit to the Commission WHO's forthcoming First Report on the World Health Situation.

In subsequent discussions between WHO leadership and the UN Division of Human Rights, however, WHO staff noted the irrelevance of this technical Report on the World Health Situation to the work of the Commission of Human Rights:

³⁴⁷ Letter from WHO Deputy Director-General P. Dorolle to UN Deputy Under-Secretary for Economic and Social Affairs Martin Hill. 29 Mar. 1957.

³⁴⁸ Memorandum from WHO P. Bertrand to WHO P. Dorolle. Participation de L'OMS aux Rapports Periodiques sur les Droits de L'Homme. 23 July 1958.

³⁴⁹ WHO Report on the Fourteenth Session of the Commission on Human Rights. 10 March – 3 April 1958.

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.³⁵⁰

Consequently, WHO informed the UN Division on Human Rights that while it would submit its Report on the World Health Situation, the UN Secretariat need not include a section on health in its human rights summary. Unwilling to allow WHO to shirk these reporting requirements and deny health a place in the annals of human rights progress, the UN 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."³⁵¹ Nevertheless evading this responsibility, 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, with the Director-General noting in his submission that "none of the

³⁵⁰ Memorandum from WHO Liaison B. Howell to WHO Assistant Director-General M.P. Bertrand. Periodic Reports on Human Rights. Notes of Conversation with Mrs. Bruce of the UN Department of Human Rights – 4 July 1958. 7 July 1958 (emphasis in original).

³⁵¹ Letter from UN Under-Secretary in charge of Special Political Affairs Humphrey Trevelyan to WHO Deputy Director-General P. Dorolle. 21 Aug. 1958.

documents . . . have [sic] been prepared for the purpose of aiming at the protection of a human right . . .”³⁵²

In the wake of these tensions and castigations, WHO attempted to excise itself entirely from the reporting process on measures of progress in the protection of human rights. In January 1959, the UN Secretary-General had proposed to the Commission on Human Rights that member states report directly to specialized agencies on the human rights within their purview – listing the ILO, UNESCO and WHO as part of this reporting system under UDHR articles 22 to 27 and specifically noting that “states members of the WHO should report to that agency on matters relating to the right to health as set forth in article 25 of the Universal Declaration.”³⁵³ Upon receipt of this proposal, the WHO Director-General’s Office reacted impetuously, insisting successfully that the UN Secretariat delete any mention of WHO in its proposal. Positing anew that article 25 dealt far more with “social questions” than with health, WHO suggested that the UN would be the only appropriate reviewing agency for the UDHR’s obligations on underlying determinants of health.³⁵⁴⁻³⁵⁵ At the request of the UN Division of Human Rights, WHO 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

³⁵² Letter from WHO Director-General M.G. Candau to UN Secretary-General. N64/86/38. 12 Feb. 1959.

³⁵³ Commission on Human Rights. Periodic Reports on Human Rights: Memorandum by the Secretary-General. E/CN.4/776. 27 Jan. 1959.

³⁵⁴ Memorandum from Deputy Director-General P. Dorolle to Director, LUN. Rapports Periodiques sur les Droits de L’Homme. 5 Feb. 1959.

³⁵⁵ Memorandum from WHO Director, Liaison Office with United Nations Michael Sacks to WHO Deputy Director-General P. Dorolle. Periodic Reports on Human Rights. Your cable no. 6 of 4 February and your letter of 5 February 1959, Re. N/64/180/5. 9 Feb. 1959.

competence of the World Health Organizations and would therefore not lend themselves to a direct reporting by Governments to this Organization”³⁵⁶

With WHO responses repeatedly at odds with those of other specialized agencies, the subject of WHO’s human rights dereliction was again taken up by the Commission on Human Rights in 1959, with the WHO representative reiterating the Organization’s firm position under withering criticism from the Commission Chairman. In doing so, the WHO representative responded that its report on human rights, while not “prepared with a view to the protection of a human right,” could nevertheless assist the Commission in its work.³⁵⁷ With the Commission on Human Rights eventually relenting in its criticisms of WHO reports, the WHO representative reached an accommodation with the Commission Rapporteur, whereby the recorded WHO position was amended to read:

In a statement circulated to the Commission (E/CN.4/776/Add.2) the Deputy-Director General of WHO states that Article 25 of the Universal Declaration went beyond the competence of WHO and did not lend itself to the direct reporting by Governments to the Organization, *but the Director-General would consider arrangements under which WHO might assist in studying reports on health questions received by the Secretary-General under this Article.*³⁵⁸

³⁵⁶ Letter from WHO Deputy Director-General P. Dorolle to UN Division of Human Rights Director J. Humphrey. 4N64/418/2. 24 Feb. 1959.

³⁵⁷ Memorandum from WHO Liaison Office with United Nations Director to WHO Deputy-Director General. Report on the Fifteenth Session of the Commission on Human Rights. 21 Apr. 1959.

³⁵⁸ Id. (emphasis added).

Despite (or possibly because of) this conditional offer of assistance, (1) states did not submit reports to WHO on the right to health, (2) the UN never formally requested WHO comment on UN reports pursuant to article 25, and (3) WHO resisted all efforts to submit triennial reports to the UN in the years following WHO's repudiation of health rights.³⁵⁹⁻

³⁶³

When it came time for the UN Secretariat to prepare its 1968 review of the efforts taken in conjunction with specialized agencies in the field of human rights, its statement on the right to health includes only vague and perfunctory generality on WHO's activities – 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.”³⁶⁴ Although WHO deviated from its pro forma denial of information in 1969, its slightly more detailed response—listing its attendance at the aforementioned human rights seminars and participation in commemorations of the

³⁵⁹ Letter from WHO Deputy Director General P. Dorolle to UN Under-Secretary for Special Political Affairs C.V. Narasimhan. SO 214 (2-1-2). 11 July 1960.

³⁶⁰ Letter from WHO Deputy Director General P. Dorolle to UN Division of Human Rights Director John P. Humphrey. N64/180/5. 7 Feb. 1963.

³⁶¹ Letter from WHO Assistant Director-General L. Bernard to UN Division of Human Rights Deputy Director Edward Lawson. SO 214 (2-1-2) 1965-67. 4 Oct. 1965.

³⁶² Letter from WHO Assistant Director-General L. Bernard to UN Division of Human Rights Director Marc Schreiber. SO 214 (2-1-2) 1963-66. 23 Sept. 1966.

³⁶³ Letter from WHO Division of Co-ordination and Evaluation Director A. Bellerive to UN Division of Human Rights Director Marc Schreiber. SO 214 (2-1-2) 1965-68. 11 July 1968.

³⁶⁴ United Nations. *The United Nations and Human Rights*. United Nations: New York. 1968.

twentieth anniversary of the UDHR—nevertheless continued WHO’s position that its functions were exclusively technical, resulting in the publication of exclusively technical reports.³⁶⁵ Without WHO periodic reports on human rights or state health reports under human rights treaties, the right to health would be marred by over fifteen years of stasis, with the absence of enforcement standards from the world’s preeminent health agency denying states the guidance necessary for the implementation of health rights.

c. Awareness

To raise widespread awareness in support of human rights implementation, the UN has developed year-long anniversary celebrations for the UDHR to (1) recognize past accomplishments of the UN in promoting human rights, (2) publicize specific substantive rights of the UDHR, and (3) stimulate policy discussions on human rights advancement. Culminating with observances on Human Rights Day, December 10 (the anniversary of the proclamation of the UDHR), the UN sought to work with all of its specialized agencies to employ these celebrations to advance discourse on the human rights within their respective purview. With vocal disinterest in these human rights, WHO rebuffed these UN efforts, avoiding its responsibilities to raise awareness of the right to health as a tool for health advocacy and a framework for national policy.

To coordinate the efforts of the UN, member states, and specialized agencies in marking the 1958 tenth anniversary of the UDHR, the Commission on Human Rights appointed a committee (including a requested representative from WHO) to plan human

³⁶⁵ Letter from WHO Division of Co-ordination and Evaluation Director A. Bellerive to UN Division of Human Rights Director Marc Schreiber. SO 214 (2-3-2) 1966-69. 26 Nov. 1968.

rights awareness-raising activities and create complementary anniversary celebrations throughout the world. Based on the committee's recommendation, ECOSOC suggested that WHO take several specific steps in observance of the tenth anniversary – including the publication of a report on its human rights programming, the dissemination of public information on the right to health, the participation in a special UN General Assembly meeting on the UDHR, and the creation of WHO human rights programs on December 10.³⁶⁶ Ignoring these recommendations, WHO had already decided months earlier that its participation would be limited to (1) preparing a written message for the General Assembly and (2) attending the European Office of the UN's December 10 ceremony for Human Rights Day.³⁶⁷⁻³⁶⁸ With other specialized agencies planning far more robust activities—including publications, museum displays, films, public seminars, and commemorative programs³⁶⁹—the UN suggested a compromise by which WHO simply include reference to the right to health in WHO's previously planned celebrations for the tenth anniversary of the WHO Constitution. Despite this plaintive request for only a modicum of activity, WHO's Deputy Director-General reacted dismissively to this UN

³⁶⁶ Letter for UN Department of Economic and Social Affairs Officer-in Charge William R. Leonard to WHO Director-General Marcolino Gomes Candau. 27 Aug. 1957 (enclosing ECOSOC. Observance of the Tenth Anniversary of the Adoption of the Universal Declaration of Human Rights. 24 July 1957).

³⁶⁷ Memorandum from WHO P. Bertrand, ERTA to WHO Deputy Director-General. Tenth Anniversary of the Universal Declaration of Human Rights. 21 Feb. 1957 (handwritten notes by Director-General Candau).

³⁶⁸ Letter from WHO Director-General M.G. Candau to UN Under-Secretary for Economic and Social Affairs. 3 Oct. 1957.

³⁶⁹ E.g., Letter from UNESCO Public Liaison Division to UNESCO Member States. MC/PLD/CL/6A. 2 May 1968 (enclosing Human Rights Day 1958: Suggestions for Tenth Anniversary Year).

compromise—questioning in internal notes to WHO staff whether the UN was “prepared to reciprocate by drawing attention to WHO’s tenth anniversary in the course of their own celebration”—and recommended to the Director-General only that WHO “include a word or two . . . but nothing more” on human rights.³⁷⁰ Although WHO staff briefly acceded to the UN’s repeated requests to promote the anniversary of the UDHR by publishing an article on the right to health,³⁷¹ WHO eventually reneged on both the publication of an article and the presentation of an official statement before the UN General Assembly.

When it came time to commemorate the fifteenth anniversary of the UDHR under a similar set of UN recommendations,³⁷² WHO’s legal office dismissed this collaboration outright—commenting internally that “our direct concern with human rights is somewhat shaded” (based on the Director-General’s 1959 policy statement on human rights reporting)³⁷³—with the Secretariat leadership limiting WHO’s 1963 cooperation only “to participate appropriately in any celebration that might take place at the European Office of the UN in Geneva.”³⁷⁴⁻³⁷⁵

³⁷⁰ Letter from UN Deputy Under-Secretary for Economic and Social Affairs to WHO Director-General M.G. Candau. 11 November 1957 (handwritten notes of WHO Deputy-Director General P. Dorolle).

³⁷¹ Memorandum from WHO LUN PIO R. Morse to WHO LUN Director R. L. Coigney. Tenth Anniversary of the Universal Declaration of Human Rights. 2 Dec. 1957.

³⁷² ECOSOC Resolution 940 (XXXV). Fifteenth Anniversary of the Universal Declaration of Human Rights. 1258th Plenary Meeting. 15 Apr. 1963.

³⁷³ Memorandum from WHO Legal Office Chief Frank Gutteridge to WHO Deputy Director-General P. Dorolle. 15th Anniversary of Universal Declaration of Human Rights. 12 January 1963.

³⁷⁴ Memorandum from WHO Director, Liaison Office with United Nations to WHO Deputy Director-General P. Dorolle. Special Committee for the Preparation of Plans for

In UN preparations for the significantly more robust activities of the 1968 International Year of Human Rights—a commemoration of the twentieth anniversary of the UDHR; a yearlong review of the human rights efforts of the UN, member states, and specialized agencies; and a period of intensified activities and undertakings to raise awareness of human rights³⁷⁶—WHO immediately sought to distance itself from the development of a “programme of measures and activities” for the UN and its specialized agencies. Internally, WHO arranged to avoid preparatory committee meetings, with the Deputy Director-General writing to WHO’s UN Liaison as early as 1964 that:

[T]he United Nations programme of human rights has little bearing on our work[,] and the many special campaigns which we are expected to support are proving a real burden . . . So it is advisable for the WHO Representative at this Committee to go no further than is strictly required by courtesy.

To finalize WHO’s policy position with regard to the International Year for Human Rights, WHO’s Deputy Director-General prepared the following official Statement on Co-Operation with the UN Committee on the International Year for Human Rights:

The technical functions with which WHO is entrusted by its Constitution are designed to give effect to the right to health by improving health conditions. *Other measures to ensure respect for human rights, such as*

the Celebration of the Fifteenth Anniversary of the Universal Declaration of Human Rights. 1 Feb. 1963.

³⁷⁵ Letter from WHO External Relations Chief C. Fedele to UN Chef de Cabinet C.V. Narasimhan. 17 June 1963.

³⁷⁶ Designation of 1968 as International Year for Human Rights. UN Resolution 1961 (XVIII). General Assembly. 12 December 1963.

*legislation, do not come within the competence of WHO. . . . Its co-operation in the observance of the International Year for Human Rights must therefore be restricted to technical activities that relate directly to health and to public information work that can be carried out within existing budgetary provisions.*³⁷⁷

Although WHO's announced "public-information type activities" for the International Year of Human Rights sought to avoid any discourse on health rights,³⁷⁸⁻³⁷⁹ UN General Assembly mandates for more "intensified programmes"³⁸⁰⁻³⁸¹ would lead WHO to agree to take part in the UN's 1968 International Conference on Human Rights.³⁸²

As part of the UN's programming for the International Year for Human Rights, the Commission on Human Rights developed this International Conference for Human Rights in Tehran, Iran to (1) review the progress of human rights since the UDHR, (2) evaluate the effectiveness of UN promotion of human rights, and (3) prepare a

³⁷⁷ Memorandum from Deputy Director-General P. Dorolle to LUN Director, Committee on International Year for Human Rights. 29 June 1964 (emphasis added).

³⁷⁸ Memorandum from Director, Liaison Office with United Nations to L. Bernard, Assistant Director-General, Commission on Human Rights Twenty-Second Session. 14 April 1966.

³⁷⁹ Letter from WHO Assistant Director-General L. Bernard to UN Director of the Division of Human Rights Marc Schreiber. PU 112/2(11). 6 March 1967.

³⁸⁰ UN General Assembly. Resolution 2081 (XX). 20 Dec. 1965.

³⁸¹ UN General Assembly. Resolution 2217 (XXI). 19 Dec. 1966.

³⁸² Telegram from Director of the Liaison Office with the United Nations Rodolphe L. Coigney (New York) to Bernard (Geneva). 13 April 1967.

programme of future actions following the adoption of the ICCPR and ICESCR.³⁸³ In preparations for this Conference, ILO and UNESCO—both of which had already prepared and adopted relevant human rights conventions—presented extensive agenda-setting comments to the Commission on Human Rights in 1966 and 1967 and agreed to submit reports to the Conference on relevant human rights. WHO, in accordance with its internal policy, remained absent from many of these early meetings and made no comment in those it attended.³⁸⁴ Once WHO had reluctantly agreed to participate in this Conference, selecting for representation the Director of the WHO Regional Office for the Eastern Mediterranean (and, on his leaving after one week, the Senior WHO Adviser on Malaria Eradication in Iran),³⁸⁵ the Secretariat staff worked across divisions to prepare WHO's required report to the Conference. Despite the clear human rights focus of other specialized agency reports, WHO's report, "The Right to Health – Its Implications in WHO's Programme of Work," discussed only WHO's technical programs rather than states' implementation of health rights.³⁸⁶ Although the WHO Director of the Regional Office for the Eastern Mediterranean would speak far beyond this written report in his

³⁸³ United Nations Office of Public Information. International Year for Human Rights Newsletter. 1967;1:1-38.

³⁸⁴ Memorandum from Director, Liaison Office with the United Nations to ADG L. Bernard. Preparatory Committee for the International Conference on Human Rights. 27 Feb. 1967.

³⁸⁵ Letter from Regional Director A.H. Taba to Senior WHO Adviser S.C. Edwards. RD.4/8. 2 Apr. 1968.

³⁸⁶ International Conference on Human Rights. Report Submitted by the World Health Organization. A/CONF.32/8. 24 Jan. 1968. Notwithstanding this technical discussion in its report, WHO structured its discussion on the basis of underlying conditions of health that would soon become the basis of WHO's approach to 'primary health care': care of mothers and children, nutrition, prevention and control of communicable diseases, sanitation and water supply, health education, and occupational health.

address to the Conference—announcing, in an overstated way not reviewed by WHO headquarters, that “[t]he World Health Organization, during the past twenty years, has consistently strived to deepen the search for agreement on the requirements of health and to ensure exercising of this human right in the light of contemporary technical progress”³⁸⁷—WHO’s official position was by then widely known. Despite this late-breaking individual initiative, the resolutions rising out of the Conference on Human Rights did not address health rights in anything more than passing mention,³⁸⁸ an omission reflecting WHO’s longstanding absence in the development of human rights norms and the implementation of human rights obligations.

Outside of this Conference, WHO continued to limit its human rights activities in the 1968 International Year of Human Rights strictly to public information:

- (1) mentioning the anniversary of the UDHR briefly during WHO anniversary celebrations and radio interviews,
- (2) mentioning human rights briefly in an article in the March (WHO anniversary) issue of *World Health*, and
- (3) mentioning the UDHR briefly in the October issue of *World Health* (in its discussion of “mentally retarded and physically handicapped children”).³⁸⁹

³⁸⁷ World Health Organization, Regional Office for the Eastern Mediterranean. Address by Dr. A.H. Taba, Regional Director at the International Conference [sic] on Human Rights. Teheran. 22 April – 13 May 1968.

³⁸⁸ Memorandum from WHO EMRO Regional Director A.H. Taba to WHO Director-General M.G. Candau. International Conference on Human Rights. RD.WHA21/51. 30 May 1968.

³⁸⁹ Philip Noel-Baker. Human Rights in 1968. *World Health*. Oct-Nov 1968: 3-5.

When the UN Secretary-General submitted his comprehensive report to the General Assembly on “Measures and Activities Undertaken in Connexion [sic] with the International Year of Human Rights,” it included activities taken by nearly every international organization (ILO, FAO, UNESCO, International Telecommunication Union, Universal Postal Union, and the World Meteorological Organization) – but not WHO.³⁹⁰ With the UN Division of Human Rights recognizing other specialized agencies for their commitment to human rights, WHO staff sought to rectify what they perceived to be an intentional UN slight of their informational activities,³⁹¹ presenting in its defense a prepared statement to the Third Committee of the General Assembly “expanding on the concept of man’s right to health” but failing to engage with the legal obligations of the human right to health.³⁹²

C. WHO Rediscovers Human Rights (1973-1979)

By the early 1970s, there was a return to the promise of international human rights standards as a means to realize improved standards of global health. Concurrent with the expansion of the broader human rights movement,³⁹³ human rights

³⁹⁰ UN General Assembly. International Year for Human Rights. Measures and Activities Undertaken in Connexion with the International Year for Human Rights. Report of the Secretary-General. A/7195. 24 Sept. 1968.

³⁹¹ Memorandum from ADG Bernard to UN Liaison. International Year for Human Rights. N64/180/5 (b). 10 Oct. 1968.

³⁹² Memorandum from Director, Liaison Office with United Nations to WHO ADG Bernard. UN General Assembly – Twenty-Third Session. 31 Dec. 1968.

³⁹³ Donnell J. International human rights: A regime analysis. *International Organization*. 1986;40:599-642.

organizations,³⁹⁴ and human rights instruments,³⁹⁵ WHO would seek to expand its influence on underlying determinants of health by redefining its health goals to reflect human rights standards. With a 1973 change in WHO leadership, WHO began attending sessions of the Commission on Human Rights and collaborating with the UN's human rights staff. Increased human rights coordination among specialized agencies within the UN system would buttress WHO efforts,³⁹⁶ providing added collaborative opportunities in human rights advancement for health.³⁹⁷⁻³⁹⁸ Through these collaborative efforts, the WHO leadership would hold out human rights as a force for health, using international negotiations, articles, and conferences to promote the relevance of the right to health to public health practice and extolling human rights obligations as a clarion call to the achievement of health for all.

Understandings of health had changed dramatically in the twenty-five years since the founding of WHO. With the end 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

³⁹⁴ Tsutsui K, Wotipka CM. Global Civil Society and the International Human Rights Movement: Citizen Participation in Human Rights International Nongovernmental Organizations. *Social Forces*. 2004;83(2): 587-620.

³⁹⁵ Moon R. *From Charity to Human Right: Discourse and Global Expansion of Health and Health Education, 1650-1997*. Stanford University Dissertation; 2003.

³⁹⁶ Annual Report of the Administrative Committee on Co-ordination 1973-74. E/5488.

³⁹⁷ E/CN.4/1193. 1976.

³⁹⁸ E/CN.4/1433. 1980.

correlations among increasing poverty, inequality, and ill-health,³⁹⁹ the perceived emergence of new threats—in the form of heart disease, cancer, labor migration and exploitation, drug addiction, overpopulation, and environmental harms (threats of predominant concern to developed states)—were shifting public health toward an emphasis on the prevention of social, “lifestyle” determinants of disease.⁴⁰⁰ 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 re-appearing everywhere with new and intensified manifestation.”⁴⁰¹ Compounded by the 1969 arrival of “Hong Kong influenza”—highlighting the ways in which new harms could spring from crowded cities, spreading thereafter throughout the world⁴⁰²—scholars focused more intently on the role of weak national health systems in enabling the spread of disease.⁴⁰³ With an understanding that improving medical care was limited in promoting health and preventing disease, scholars turned their attention from nostrums to environments.⁴⁰⁴

³⁹⁹ Dasgupta B, Seers D. *Statistical Policy in Less Developed Countries*. Brighton, UK: Institute of Development Studies; 1975.

⁴⁰⁰ Curtis S, Taket A. *Health and Societies: Changing Perspectives*. London: Arnold; 1996.

⁴⁰¹ Dubos R. *Man Adapting*. New Haven: Yale University Press; 1965: 237-238.

⁴⁰² *WHO Chronicle*. June 1970. 269.

⁴⁰³ Litsios S. A programme for research in the organization and strategy of health services. Paper presented at the WHO Director General’s Conference. Geneva, Switzerland. 25 June 1969.

⁴⁰⁴ Wildavsky A. Doing better and feeling worse: The political pathology of health policy. In Knowles JH (Ed.). *Doing Better and Feeling Worse*. New York: WW Norton; 1977.

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.⁴⁰⁵⁻⁴⁰⁶ 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.”⁴⁰⁷ Given a growing gap between what could be done and what was being done to address these underlying determinants of health, scholars and practitioners began to examine national health systems—including administration, regulation, and financing decisions beyond the individual delivery of health services—moving public health beyond the purview of the physician to encompass a range of health personnel and infrastructures.⁴⁰⁸⁻⁴⁰⁹

Through this growing consensus in public health discourse, WHO began in the late 1960s—before its 1973 change in leadership—to make the development of national health systems a principal component of its technical assistance and cooperation, with

⁴⁰⁵ Rosen G. *From Medical Police to Social Medicine: Essays on the History of Health Care*. New York: Science History Publications; 1974.

⁴⁰⁶ Scrimshaw NS. Myths and realities in international health planning. *American Journal of Public Health*. 1974;64(8):792-798.

⁴⁰⁷ McKeown T. *The Role of Medicine: Dream, Mirage, or Nemesis?*. Oxford: Blackwell; 1976: 179.

⁴⁰⁸ Evang K. Human rights: Health for everyone. *World Health*. 1973;Nov.:3-11.

⁴⁰⁹ Etzioni A. Health as a social priority. *Academy of Political Science Proceedings*. 1977;32(3):8-14.

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.⁴¹⁰ Given its past neglect of underlying determinants of health, WHO's previous health planning had simply promoted the export of Western medical models to the developing world, diverting health resources from public health systems to urban medical facilities specializing in curative care – caring for wealthy elites rather than those in greatest need.⁴¹¹⁻⁴¹² 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.”⁴¹³ With the failures of WHO’s disease eradication programs (e.g., the end of the global malaria campaign⁴¹⁴) and the successes of national health promotion systems (e.g., China’s “barefoot doctors,” seen as a means to transform the wellbeing of rural populations⁴¹⁵), WHO’s technical documents transition in the late 1960s from a persistent faith in a vertical, disease-specific technological approach to health to an increased emphasis on horizontal,

⁴¹⁰ Charles J. Origins, history and achievements of the World Health Organization. *British Medical Journal*. 4 May 1968. 293-296.

⁴¹¹ World Health Organization. Interrelationships between Health Programmes and Socioeconomic Development. Geneva: WHO; 1973.

⁴¹² Halfdan Mahler, Statement to the Second Session of the Ad Hoc Committee on the Restructuring of the United Nations in the Economic and Social Sectors, Feb. 13, 1976.

⁴¹³ L.A. Kaprio. Recent Trends in Health Service Patterns, Address to the 19th International Hospital Congress, Zagreb, June 1976, at 8.

⁴¹⁴ Pampana EJ. *Textbook on Malaria Eradication: Second Edition*. London: Oxford University Press; 1969.

⁴¹⁵ Sidel VW, Sidel R. Self-reliance and the collective good: Medicine in China. In Veatch RM, Branson R. (Eds.) *Ethics and Health Policy*. Cambridge, Mass: Ballinger; 1976.

universal ‘primary health care’⁴¹⁶ – a longstanding undercurrent in health scholarship and advocacy, addressing health care in addition to the underlying social, political, and economic determinants of health.⁴¹⁷ Under early examinations of primary health care systems, WHO established (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.⁴¹⁸ These programs and studies would reorient WHO’s work (through its newly-formed WHO Secretariat Division for Strengthening of Health Services) to assist states in creating country-specific comprehensive national plans to address underlying determinants of health.⁴¹⁹ WHO’s Fifth General Programme of Work, beginning in 1973, officially shifted WHO policy toward establishing national health promotion programs through primary health care, including programs for strengthening (1) health services, (2) disease prevention and control, (3) promotion of environmental health, (4) health manpower and development, and (5) research.⁴²⁰ In implementing this Programme, WHO reoriented its activities – programmatically (from selective medical services to equitable primary health systems)

⁴¹⁶ World Health Organization. *The Work of WHO 1966*. Geneva: WHO; 1967.

⁴¹⁷ E.g., WHO Study Group on the Measurement of Levels of Health. Geneva, Switzerland. 24-28 Oct. 1955.

⁴¹⁸ World Health Organization. *Organizational Study of the Executive Board on Methods of Promoting the Development of Basic Health Services*. EB49/WP/6. Geneva: WHO; 1972.

⁴¹⁹ Litsios S. The long and difficult road to Alma-Ata: a personal reflection. *Int'l J Health Services*. 2002;32:709–32.

⁴²⁰ World Health Assembly. Resolution 26.35. May 1973.

and geographically (from Europe to developing countries).⁴²¹

In translating these public health discourses into international legal norms, the WHO Secretariat came to recognize that human rights frameworks could move states to realize underlying determinants of health through national primary health care systems. 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 governance.⁴²² In providing this ideological backing for WHO, the World Health Assembly resolved in 1970 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:

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 nationwide system of health services based on a general national plan and local planning, and through the rational and efficient utilisation, 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.⁴²³

⁴²¹ Roscam Abbing HDC. *International Organizations in Europe and the Right to Health Care*. Deventer, The Netherlands: Kluwer; 1979: 71.

⁴²² Brown TM, Cueto M, Fee E. The World Health Organization and the transition from “international” to “global” public health. *American Journal of Public Health*. 2006;96(1):62-72.

⁴²³ World Health Assembly. Resolution 23.61. 1970 (emphasis added).

With the right to health providing a political foundation for WHO's evolving public health discourses, 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 primary health care systems. As the UN moved to celebrate its twenty-fifth anniversary of the UDHR, WHO's August 1973 message highlighted the Organization's vision to embark on a new path for health policy, a path founded upon the bedrock principles of human rights, emphasizing the rights-based language of the WHO Constitution as an equity-based framework through which to examine public health challenges:

Disease and disability are widespread, and very few countries in the world are providing to all their citizens in need the very best that medical science and technology have to offer. So the value of the right [to the highest attainable standard of health] lies in its acceptance by governments as a priority goal, its general recognition as a basis for practical health policy.⁴²⁴

Framing this rights-based vision of global public health around underlying determinants of health⁴²⁵ and reflecting the 'basic needs approach' of contemporaneous human rights scholars through programs to meet "basic health needs,"⁴²⁶⁻⁴²⁷ the WHO Secretariat would come to advocate for primary health care as a human right, and under its Health

⁴²⁴ Born to be healthy. A message from Dr. H. Mahler, Director-General of the World Health Organization. Reprinted in Secretary-General's progress report. A/9133.

⁴²⁵ Evang K. Human rights: Health for everyone. *World Health*. 1973;Nov.:3-11.

⁴²⁶ Newell KW (Ed.). *Health by the People*. Geneva: WHO. 1975.

⁴²⁷ Djukanovic V, Mach EP. *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*. Geneva: WHO; 1975.

for All strategy to primary health care, WHO would again take a leading role in developing rights-based health policy.

With the July 1973 election to Director-General of Halfdan Mahler, the Danish Assistant Director-General and Director of WHO's Program in Project Systems Analysis, WHO embarked on its Health For All Campaign as a means to advance primary health care, with specific public health targets to be achieved by the year 2000. Grounding this strategy in human rights,⁴²⁸⁻⁴²⁹ WHO would come to note that:

the Organization's fundamental objective is the promotion and protection of one dimension of human rights, namely health. This dimension encompasses the whole of WHO's activities and programmes and is particularly relevant to the Organization's social philosophy and to its main goal of health for all by the year 2000, e.g. 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.⁴³⁰

Although the rise and fall of this Health for All Campaign would be the hallmark of Director-General Mahler's fifteen-year leadership of WHO, these discourses would reach their climax in the 1978 Declaration of Alma Ata. With the Health for All strategy providing a rights-based vision reflective of public health discourse, the Declaration of

⁴²⁸ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King's College. London, England; 2001.

⁴²⁹ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁴³⁰ Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/372/1. 21 Jan. 1980 (enclosing Short Survey of WHO's Human Rights Activities).

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

1. Human Rights Implementation – WHO Prioritizes Human Rights in Health Programming

With its renewed belief in the applicability of human rights obligations to achievement of public health outcomes, the WHO Secretariat sought to strengthen the implementation of existing human rights frameworks for health. Through its reporting to the Commission on Human Rights, inter-agency human rights collaborations for underlying determinants of health, and human rights education on the right to health, WHO created programs to assist in the implementation of health rights at the national and international level.

a. Reporting

After years of neglect for human rights reporting, the WHO Secretariat submitted its first full Periodic Report on Human Rights in April 1974, covering its expanding activities in economic, social and cultural rights from 1969 to 1973. Signaling a new responsiveness to the human right to health, this periodic report—enumerating World Health Assembly resolutions, UN human rights seminars, and WHO human rights publications⁴³¹—indicated that WHO would be increasing its reporting activities to assure state realization of human rights. These human rights implementation efforts would expand as states moved toward the January 1976 entry into force of the ICESCR's article

⁴³¹ Letter from WHO Deputy Director-General T.A. Lambo to UN Under-Secretary-General for Political and General Assembly Affairs Bradford Morse. SO 214(2-3-4) 1969-1973. 16 Apr. 1974.

12 right to the “highest attainable standard of physical and mental health,” with WHO seeking anew to have a seminal role in the review of state reports on the right to health.

As it became clear that a sufficient number of states would soon ratify the 1966 human rights covenants (ICCPR and ICESCR) and bring them into force, the UN Division of Human Rights brought together representatives from the UN’s specialized agencies in September 1974 to coordinate implementation mechanisms pursuant to the promulgation of the ICESCR. This ad hoc meeting, organized by the UN’s Administrative Committee on Co-Ordination, sought to clarify the authority of each specialized agency to undertake standard-setting activities to implement the ICESCR through organizational procedures.⁴³² To facilitate consistency and predictability in state reporting on the various rights of the ICESCR, each specialized agency agreed to elaborate guidelines for state reports on the rights within their respective purview and competence, with these guidelines then harmonized by the Administrative Committee on Co-Ordination and codified by ECOSOC as a uniform set of reporting guidelines.⁴³³

In WHO’s December 1975 working paper on implementation of the Covenants,⁴³⁴ the WHO Secretariat highlighted its widespread concern for civil and political and economic, social and cultural rights, reviewing organizational positions on, *inter alia*,

⁴³² Administrative Committee on Co-Ordination. Ad hoc Meeting of the United Nations and Specialized Agencies Concerned with the Implementation of the International Covenants on Human Rights, Geneva, 9-10 September 1974. CO-ORDINATION/R.1065. 16 Sept. 1974.

⁴³³ Letter from UN Division of Human Rights Director Marc Schreiber to WHO Coordination Chief Michael Sacks. G/SO 221/9 (1-6). 17 June 1975.

⁴³⁴ Letter from WHO Co-ordination with other Organizations Chief Michael R. Sacks to UN Division of Human Rights Studies and Conventions Section Chief Henri Mazaud. 4N64/372/3. 23 Dec. 1975 (enclosing Working paper by WHO to the Inter-Agency Meeting on the Implementation of the Human Rights Covenants).

ICESCR articles 7 (safe and healthy working conditions), 10 (family health, child and mother protections), 11 (adequate standards of living), 12 (health), 15 (scientific research), 16-18 (reporting), 20 (comments to ECOSOC), 22 (ECOSOC reports), 23 (international action), and 24 (impairment of the WHO Constitution). By linking each of these ICESCR articles to specific authority granted to it under the WHO Constitution, WHO reversed course and made the case for its review of an extensive array of state reports pursuant to the ICESCR. Notwithstanding this expansive concern, WHO gave preeminent focus to the right to the highest attainable standard of physical and mental health in article 12, arguing that “this provision is of primary importance from WHO’s point of view, and the whole body of WHO activities is based on the right and principles contained therein.”⁴³⁵ Further to this interest in the implementation of the right to health and rights to various underlying determinants of health, WHO’s working paper reviewed its: standard-setting activities (focusing on its development of food, biological, and pharmaceutical standards), internal policies (listed in an internal WHO manual), and constitutional authorities to draft international health law through conventions, regulations, and recommendations.

With the ICESCR entering into force on January 3, 1976, the Administrative Committee on Co-Ordination met for a second time from January 14 to 16 to review the suggestions of specialized agencies for implementation of the human rights covenants through uniform agency standards. To add necessary legal detail to these implementation standards, the WHO Secretariat joined other specialized agencies in assuring that the Organization would be represented by a member of its legal staff in these standard-setting

⁴³⁵ Working paper by WHO to the Inter-Agency Meeting on the Implementation of the Human Rights Covenants. 3.

discussions. (Although human rights matters had traditionally been outside of the legal office's terms of reference—with the legal office long concerned by any transfer of authority for human right matters to its already limited staff⁴³⁶—the legal office had taken responsibility for, and provided extensive legal detail to, WHO's 1975 working paper of suggestions for implementation of the ICESCR.⁴³⁷) In developing common inter-agency legal suggestions for recommendation to ECOSOC, the Administrative Committee on Co-Ordination discussed (1) the process of disseminating state reports to specialized agencies, (2) the manner in which specialized agencies would comment on those reports, (3) the resources to be provided by the UN Secretary-General to undertake this added workload, and (4) the timing of specialized agency report submissions to the UN.⁴³⁸ With the ICESCR requiring disaggregated state reports on each individual right, the Administrative Committee on Co-Ordination agreed to a staggered reporting arrangement as a means to protract the report deadlines and alleviate the burden on states and international organizations. Creating a six-year cycle for state reporting on groups of economic, social and cultural rights, article 12 reports on the right to the health would be

⁴³⁶ Memorandum from WHO LEG Director F. Gutteridge to WHO CWO Chief. Meeting on Human Rights. 4N64/372/3. 3 Dec. 1975.

⁴³⁷ Letter from WHO Co-ordination with other Organizations Chief Michael R. Sacks to UN Division of Human Rights Studies and Conventions Section Chief Henri Mazaud. 4N64/372/3. 23 Dec. 1975.

⁴³⁸ Memorandum from WHO CWO R. Anderson to WHO CWO Chief. Interagency Meeting re Implementation of Human Rights Covenants (Geneva, 14-16 January 1976). CWO-4N64/372/3. 22 Jan. 1976.

scheduled for submission in the fourth reporting year, beginning in 1980 and coinciding with WHO's specialized agency report on human rights.⁴³⁹

On the basis of this preparatory work, the UN Secretary-General prepared recommendations for ECOSOC on the harmonized reporting procedures for human rights implementation. In implementing the ICESCR, WHO sought (1) to serve as the responsible reviewing body with respect to article 12 reports—reporting directly to ECOSOC on the right to health and reviewing states party reports on this right—and (2) to serve cooperatively with other specialized agencies with respect all other articles governing underlying determinants of health.⁴⁴⁰ Although ECOSOC member states were reluctant to embrace this expansive leadership role for specialized agencies, with a preference for state control in reviewing state reports, the specialized agencies agreed to work with states in ECOSOC working groups for the rights that fell within their respective fields of competence.⁴⁴¹ With WHO observers noting their “impression [] that ECOSOC is not proceeding from any fixed anti-agencies position but feeling its way in new territory,”⁴⁴² WHO resolved to work closely with these ECOSOC working groups as ECOSOC put these implementation procedures into effect for human rights to underlying determinants of health.

⁴³⁹ Letter from UN Division of Human Rights Director Marc Schreiber to WHO Director-General Halfdan Mahler. G/SO 221/9(1). 3 Feb. 1976.

⁴⁴⁰ Memorandum from WHO CLM S. Shubber and WHO CWO R.J. Anderson to WHO LEG Director F. Gutteridge. WHO Involvement Concerning Implementation of Human Rights Covenants. CWO-4N64/372/3. 20 Feb. 1976.

⁴⁴¹ ECOSOC. Resolution 1988 (LX). Procedures for the Implementation of the International Covenant on Economic, Social and Cultural Rights. 11 May 1976.

⁴⁴² Telegram from WHO LUN Malafatopoulos to WHO LUN Sacks. 23 Apr. 1976.

First, as ECOSOC began to review state reports on measures adopted and progress made in realizing the rights recognized in the ICESCR—starting in 1977 with articles 6 to 9⁴⁴³—the WHO Secretariat worked across its substantive units and collaborated with other specialized agencies to comment on state human rights reports as they related to underlying determinants of health.⁴⁴⁴ In preparing for states to report in 1980 on the rights recognized in articles 10 to 12, the UN Division of Human Rights reached out to WHO in finalizing the general guidelines for state reporting on measures, progress, and difficulties in fulfilling the right to health,⁴⁴⁵ with WHO both offering comments and observations on the health implications of article 10 and suggesting that article 12 “be dealt with in a more ‘open-ended’ manner” to alleviate government difficulties in providing the specific information sought by the guidelines.⁴⁴⁶ With 21 states submitting initial reports on article 12 of the ICESCR, these state reports were forwarded to WHO for review throughout 1979 and into 1980.⁴⁴⁷

⁴⁴³ Letter from UN Division of Human Rights Assistant Director, Officer-in-Charge Henri Mazaud to WHO Director-General Halfdan Mahler. G/SO 221/911(2). 9 Dec. 1977.

⁴⁴⁴ E.g., Letter from WHO Division of Coordination Acting Director O.W. Christensen to UN Division of Human Rights Assistant Director, Officer-in-charge H. Mazaud. CWO-4N64/372/3. 24 Apr. 1978 (enclosing International Covenant on Economic, Social and Cultural Rights – Article 7(b): Report by the World Health Organization).

⁴⁴⁵ Letter from UN Division of Human Rights Director Theo C. van Boven to WHO Director-General Halfdan Mahler. G/SO 221/911(2). 20 Feb. 1979 (enclosing General Guidelines for Reports on Articles 10-12 of the International Covenant on Economic, Social and Cultural Rights).

⁴⁴⁶ Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/372/1. 5 Apr. 1979.

⁴⁴⁷ E.g., Letter from UN Division of Human Rights Director Theo C. van Boven to WHO Director-General Halfdan Mahler. G/SO 221/911. 21 Dec. 1979 (enclosing state reports from the governments of Mongolia and Sweden).

Second, seeking to create complementary mechanisms to assure implementation of the right to health, WHO came to support state efforts to strengthen the Commission on Human Rights and to establish the long-stalled position of UN High Commissioner for Human Rights. Under the UN General Assembly's 1977 debate on "Alternative approaches and ways and means within the United Nations system for improving the effective enjoyment of human rights and fundamental freedoms,"⁴⁴⁸ WHO's contribution to this issue—while not responsive to the legal specificity of alternate proposals—sought to frame WHO's conception of a right to health and the role of primary health care in realizing underlying determinants of health under WHO's objective of health for all:

The awareness of social justice and the rights of the individual motivates the Organization's constant search for new ways and means to achieve the greatest health benefit for the greatest number of people at the lowest cost.

. . . Primary health care represents a framework or approach for delivering a range of vital health programmes so that benefits could reach the widest possible number of people. . . [and] goes a long way towards establishing a more equitable and adequate distribution of health resources, particularly for the benefit of the least served, the social periphery.⁴⁴⁹

⁴⁴⁸ United Nations General Assembly. Res. 32/130. Alternative approaches and ways and means within the United Nations stystem for improving the effective enjoyment of human rights and fundamental freedoms. 16 Dec. 1977.

⁴⁴⁹ Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/372/1. 31 Oct. 1978 (enclosing Alternative Approaches and Ways and Means within the United Nations System for Improving the Effective Enjoyment of Human Rights and Fundamental Freedoms: Contribution of the World Health Organization).

Given this expanding interpretation of the right to health, WHO saw the appointment of a High Commissioner for Human Rights as bringing a welcome adjudicator to the implementation of health rights for underlying determinants of health.

Finally, building from this renaissance in human rights cooperation for health, WHO elicited information from states for its own ECOSOC report. Seeking to establish procedures to collect information on health rights without either burdening states with extraneous requests or requiring WHO to hire additional legal staff,⁴⁵⁰ the WHO Secretariat sought to work with the UN as early as 1976 “to study how we can effectively obtain information related to the implementation of the various Articles of the international Covenant [ICESCR] that concern us, at the same time as that used for the preparation of the world health situation reports.”⁴⁵¹ With the WHO legal and coordination offices reaching out to the WHO Working Group on the World Health Situation Reports in developing efficient procedures to collect state information,⁴⁵² this Working Group agreed that its own six-year review at the end of 1979 could assure the consolidated collection of information from states for WHO’s specialized agency report on human rights. Given that article 12 “covers the whole range of WHO’s activities,” the Working Group worked with the WHO legal office (1) to “formulate the scope and

⁴⁵⁰ Memorandum from WHO CLM S. Shubber and WHO CWO R.J. Anderson to WHO LEG Director F. Gutteridge. WHO Involvement Concerning Implementation of Human Rights Covenants. CWO-4N64/372/3. 20 Feb. 1976 (handwritten comments by WHO LEG Director F. Gutteridge).

⁴⁵¹ Letter from WHO Division of Co-ordination Associate Director Michael R. Sacks to UN Division of Human Rights Director M. Schreiber. CWO-4N64/372/3. 24 Feb. 1976.

⁴⁵² Memorandum from WHO LEG Director F. Gutteridge and WHO CWO Chief M.R. Sacks to WHO HST Director K. Uemura. World Health Situation Reports and Reporting on International Covenants on Human Rights. 25 Feb. 1976.

content of WHO’s report” and (2) to develop corresponding questionnaires and guidelines for state reports.⁴⁵³ With cooperation across the Secretariat and responses from a wide range of states parties on health rights, WHO submitted its report on progress made in achieving the observance of the ICESCR in February 1980,⁴⁵⁴ recognizing its past deficiencies in UN collaborations relative to other specialized agencies and admitting that it “should have played a more active and influential role in the ICESCR reporting procedure.”⁴⁵⁵

b. Inter-Agency Studies

While participating in these international policy discussions on human rights implementation, the WHO Secretariat sought to implement human rights in its own organizational programming and inter-agency collaborations. With this rights-based health programming encompassing the entirety of WHO’s public health efforts, this part focuses on those areas of inter-agency study where WHO’s human rights implementation efforts were most explicit in their adherence to international legal norms. Looking to human rights standards to govern underlying determinants of health—in areas such as human experimentation, torture, racism, child nutrition, and health technologies—WHO used these inter-agency studies as a means to apply human rights frameworks and advocacy to achieve public health ends.

⁴⁵³ Memorandum from WHO HST Director K. Uemura to WHO CWO Chief and WHO LEG Director. World Health Situation Reports and Reporting on International Covenants on Human Rights. 9 Apr. 1976.

⁴⁵⁴ Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-464/372/3. 12 Feb. 1980.

⁴⁵⁵ World Health Organization. First Report on the right to health in Article 12 ICESCR. UN doc E/1980/24 22 Feb. 1980.

i. Human Experimentation

In the absence of WHO participation in the UN's seminal work on the human rights effects of scientific and technological developments, early discussions on human experimentation were led independently by the World Medical Association (which had published the Declaration of Helsinki in 1964 to serve as a set of principles to govern physician conduct) and CIOMS (which had held a 1967 conference on Biomedical Science and the Dilemma of Human Experimentation). As these organizations advanced their ethical frameworks for human experimentation, WHO would take a greater leadership role, transitioning from technical assistance to human rights collaboration.

This inter-agency collaboration began internally in 1967 with the establishment of the WHO Secretariat Committee on Research Involving Human Subjects (SCRIHS), which advised the Director-General on research ethics and sought to establish a formal set of guiding principles for research carried out with WHO support. Based upon a September 1972 CIOMS "Roundtable Conference on Recent Progress in Biology and Medicine: Its Ethical and Social Implications," cosponsored by WHO and UNESCO,⁴⁵⁶ UNESCO thereafter suggested that it pursue greater human rights collaboration with WHO on issues of research and development in science and technology. Although the WHO Secretariat was initially ambivalent toward further commitments in human rights,⁴⁵⁷ WHO's 1973 shift brought with it a far larger role in guiding human rights discourse in human experimentation, with WHO's legal office subsequently guiding CIOMS's November 1973 Roundtable Symposium on medical ethics and human rights,

⁴⁵⁶ Letter from UNESCO Division of Philosophy Director M.P. Herzog to CIOMS Executive Secretary S. Btesh. PH/72/283. 27 Nov. 1972.

⁴⁵⁷ WHO Programme Co-ordination. Note for the Record. 4N64/445/2. 13 Dec. 1972.

“Protection of Human Rights in the Light of Scientific and Technological Progress in Biology and Medicine.”⁴⁵⁸

WHO’s human rights consultations with its nongovernmental partners would increase in subsequent years in the regulation of human experimentation. With the World Medical Association, WHO provided extensive feedback to the revision of the Declaration of Helsinki through the 1975 Declaration of Tokyo. Also beginning in 1975, WHO required that all WHO-sponsored research receive formal clearance by SCRIHS, and outside of WHO, WHO staff would work with CIOMS to gauge the applicability of clinical research review committees to enforce medical ethics in various country contexts.⁴⁵⁹ This close collaboration between WHO and CIOMS would accelerate in 1976, with WHO representatives (including legal staff) attending CIOMS’s March 1976 International Conference on the Individual and the Community in the Research, Development and Use of Biologicals to study human rights and ethical principles relevant to the use of vaccines. Given increasing inter-agency human rights frameworks for human experimentation, this WHO work with CIOMS took on added importance in 1978, with the WHO Secretariat developing a project with CIOMS to create guidelines to assist developing countries in creating mechanisms to ensure observance with medical ethics in

⁴⁵⁸ *Protection of Human Rights in the Light of Scientific and Technological Progress in Biology and Medicine*. Proceedings of a Round Table Conference Organized by CIOMS with the Assistance of Unesco and WHO. WHO Headquarters, Geneva, 14, 15, and 16 November 1973. Geneva: WHO. 1974.

⁴⁵⁹ WHO. Note for the Record. Medical Ethics: Visit by Dr. A. Gellhorn, President of CIOMS – 1 July 1976. N64/372/37. 7 July 1976.

clinical research, resulting in the 1982 publication of their “Proposed International Guidelines for Biomedical Research Involving Human Subjects.”⁴⁶⁰

ii. Torture

With the UN Sub-Commission on the Prevention of Discrimination and Protection of Minorities seeking in August 1974 to have the General Assembly take up the issue of torture in prisons, clarifying the 1955 Standard Minimum Rules for the Treatment of Prisoners,⁴⁶¹ it expanded its studies into the purview of WHO by noting the inclusion of medical personnel in torturous activities. Inviting WHO to collaborate in this effort and work with UNESCO to conceptualize a draft international code of medical ethics for the treatment of detainees,⁴⁶² WHO staff were initially divided on the advisability of such an approach to human rights implementation. While these staff recognized the importance of WHO leadership in medical ethics, they were hesitant given that all previous international codes of medical ethics had been drafted exclusively by the World Health Association,⁴⁶³ with the WHO legal office cautioning that “any ill considered or ill prepared entry by WHO into a field which so far has been dealt with on a professional basis alone could result in political and legal difficulties for the

⁴⁶⁰ Proposed international guidelines for biomedical research involving human subjects. Geneva: World Health Organization and the Council for International Organizations of Medical Sciences; 1982.

⁴⁶¹ First United Nations Congress on the Prevention of Crime and the Treatment of Offenders. Standard Minimum Rules for the Treatment of Prisoners; 1955.

⁴⁶² Telegram from WHO LUN Malafatopoulos to WHO COR Director Bellerive. 8 Aug. 1974.

⁴⁶³ Memorandum from WHO OMH D.C. Cameron to WHO PCO Chief. Human Rights of Persons Subjected to any Form of Detention or Imprisonment. N64/372/37. 2 Sept. 1974.

Organization.”⁴⁶⁴ While WHO liaisons conveyed their concerns to the resolution sponsors within the Sub-Commission on Prevention of Discrimination and Protection of Minorities—noting that medical ethics had previously been construed as outside the Organization’s constitutional competence—WHO nevertheless sought to support this effort, proposing alternate resolution language that would authorize input from the World Medical Association and would allow the WHO Secretariat to raise these issues with the Executive Board before proceeding.⁴⁶⁵⁻⁴⁶⁶ WHO began World Medical Association consultations on a new code of medical ethics in October 1974,⁴⁶⁷ and the UN, by a November 1974 General Assembly resolution, accepted WHO’s suggested collaboration scheme, wherein its resolution:

Invites the World Health Organization, taking into account the various declarations on medical ethics adopted by the World Medical Association, to draft, in close co-operation with such other competent organizations . . . as may be appropriate, an outline of the principles of medical ethics which may be relevant to the protection of persons subjected to any form of

⁴⁶⁴ Memorandum from WHO LEG Director to WHO PCO Director. Human Rights of Persons Subjected to Detention or Imprisonment. N64/372/37. 24 Sept. 1974.

⁴⁶⁵ Telegram from WHO LEG Director to WHO Liaison with the UN. N64/86/2(29). 2 Oct. 1974.

⁴⁶⁶ Telegram from WHO COR Director Bellerive to UN Liaison with the UN. 4N64/372/1. 8 Oct. 1974.

⁴⁶⁷ Memorandum from WHO OMH N. Sartorius to WHO Deputy Director-General T.A. Lambo. Coordination with World Medical Association. 16 Oct. 1974.

detention or imprisonment against torture and other cruel, inhuman or degrading treatment or punishment.⁴⁶⁸

Given the General Assembly's request that WHO provide these draft principles of medical ethics in advance of the UN's September 1975 Congress on the Prevention of Crime and the Treatment of Offenders, WHO staff immediately set to work with the World Medical Association to "prepare a legal definition of 'medical ethics,'" consulting concurrently with the Executive Board to authorize its collaborations.⁴⁶⁹ Following the Executive Board's January 1975 approval of the Secretariat's "development of principles of medical ethics,"⁴⁷⁰ WHO invited widespread collaboration in this study – from the UN Division of Human Rights,⁴⁷¹ UNESCO, and the ILO;⁴⁷² states parties; and several nongovernmental organizations, including CIOMS and Amnesty International.⁴⁷³ Through initial consultations with the World Medical Association, the preliminary WHO draft sought (1) to emphasize the health harms inherent in detention and imprisonment, (2) to define the role of the health profession in treating detainees, and (3) to emphasize

⁴⁶⁸ UNGA Res. 3218(XXIX). Torture and Other Cruel, Inhuman Degrading Treatment of Punishment in Relation to Detention and Imprisonment. 6 Nov. 1974.

⁴⁶⁹ Memorandum from WHO CWO Chief to WHO Deputy Director-General. Meeting with Sir William Refshauge, Secretary-General, World Medical Association, 5 November 1974 – Medical Ethics. 4N64/372/1. 6 Nov. 1974.

⁴⁷⁰ WHO Executive Board. EB55.R64. Jan. 1975.

⁴⁷¹ Letter from UN Division of Human Rights Director Marc Schreiber to WHO Director-General Halfdan Mahler. G/SO 214 (3-3). 18 Feb. 1975.

⁴⁷² Letter from WHO Director-General Halfdan Mahler to UN Secretary-General. 4 Mar. 1975.

⁴⁷³ Letter from WHO Co-ordination Chief Michael R. Sacks to Amnesty International Secretary-General Martin Ennals. 2 Jan. 1975.

the need for physician self-regulation while encouraging governments to formulate analogous legal protections for the underlying determinants of detainee health.⁴⁷⁴ While the official preliminary statement would be prepared by the World Medical Association—which believed international codes of medical ethics to be within its exclusive purview and which construed ‘medical ethics’ to imply a code of practice for physicians alone—an informal WHO consulting group, led by its legal office and an external consultant, met to complement this study with contributions from collaborating states⁴⁷⁵ and nongovernmental organizations.⁴⁷⁶

In its July 1975 study, *Health Aspects of Avoidable Maltreatment of Prisoners and Detainees*, WHO (1) discussed evolving human rights standards in medicine and underlying determinants of health; (2) surveyed the previous declarations of nongovernmental organizations on the treatment of offenders; and (3) proposed that all rules bearing on health be codified in a “Health Charter for Prisoners.”⁴⁷⁷ This paper was well received during its presentation at the September 1975 UN session.⁴⁷⁸ Based on this and other wide-ranging UN collaborations, the UN General Assembly adopted the

⁴⁷⁴ WHO. Notes on Meeting Between Representatives of the World Medical Association and WHO Officials. 4N64/372/1. 10 Mar. 1975.

⁴⁷⁵ E.g., Letter from United States Assistant Secretary for Health Theodore Cooper to WHO Director-General H. Mahler. 25 July 1975.

⁴⁷⁶ WHO CWO Chief M.R. Sacks. Note for the Record: Development of Principles of Medical Ethics – Implementation of Resolution EB55.R64. 28 Apr. 1975.

⁴⁷⁷ *Health Aspects of Avoidable Maltreatment of Prisoners and Detainees: Prepared by the World Health Organization for the Fifth United Nations Congress on the Prevention of Crime and Treatment of Offenders.* A/CONF.56/9. July 1975.

⁴⁷⁸ Letter from UN Crime Prevention and Criminal Justice Section Assistant Director-in-Charge G.O.W. Mueller to WHO Division of Co-ordination Director S. Flache. SO 161/2(3). 25 Sept. 1975.

Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, In-human or Degrading Treatment or Punishment in December 1975, specifically requesting that WHO clarify the principles of medical ethics applicable to this Declaration.⁴⁷⁹

Working with the World Medical Association and CIOMS to create a code of medical ethics to set “guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment,”⁴⁸⁰ WHO agreed with its nongovernmental partners that all future studies and codes on medical ethics would be undertaken through a collaboration of the World Medical Association and CIOMS, with active WHO consultation from its legal office.⁴⁸¹⁻⁴⁸³ In doing so, WHO largely deferred to the World Medical Association,⁴⁸⁴⁻⁴⁸⁵ which had taken the initiative from this experience to approve WHO’s draft at its October 1975 Congress, creating the 1975 Declaration of Tokyo, a physician code focused on torture to

⁴⁷⁹ United Nations General Assembly. Resolution 3453(XXX). 9 Dec. 1975.

⁴⁸⁰ WHO Executive Board. EB57/40. Add. 4, Annex.

⁴⁸¹ WHO CWO Director M.R. Sacks. Note for the Record – Medical Ethics. N64/372/37. 1 Mar. 1976.

⁴⁸² Memorandum from WHO CWO Chief to WHO Deputy Director-General. Medical Ethics. N64/372/37. 17 June 1976.

⁴⁸³ Memorandum from WHO COR Director to WHO LUN Director. UN General Assembly (XXXI) – Item 73 of the Provisional Agenda – “Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.” CWO-N64/372/37. 9 July 1976.

⁴⁸⁴ Letter from WHO Director-General H. Maher to UN Secreatry-General. CWO-N64/372/37. 26 Feb. 1976.

⁴⁸⁵ WHO Executive Board. Resolution 47. Coordination with the United Nations System (General Matters): Development of Codes of Medical Ethics. EB57.R47. 29 Jan. 1976.

complement earlier international codes of medical ethics under the Declaration of Helsinki. The UN took no disagreement in this delegation, with UN member states expressing their gratification for WHO's continuing efforts to further studies on medical ethics.⁴⁸⁶ In these continuing efforts, WHO would advance human rights frameworks for physician ethical codes in (1) a 1976 article in the WHO publication *World Health*,⁴⁸⁷ (2) the Commission on Human Rights' 1977 debates to develop a draft Convention Against Torture, and (3) the WHO Executive Board's 1978 endorsement of CIOMS's Principles of Medical Ethics Relevant to the Role of Health Personnel in the Protection Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

iii. Racism and Apartheid

In contrast with its early efforts to distance the Organization from the effects of racism on underlying determinants of health, WHO came in the 1970s to study the implications of racial discrimination and apartheid on health inequalities. As part of the UN Decade for Action to Combat Racism and Racial Discrimination (1973-1983),⁴⁸⁸ WHO would take an active role in studying the implications of racial discrimination and apartheid to the implementation of health rights, overcoming its previous ambivalence toward the 1971 International Year for the Elimination of Racial Discrimination through active participation within the UN system and with health justice advocates across the

⁴⁸⁶ Memorandum from WHO Liaison Office with United Nations Director to WHO Office of the Director-General. UN General Assembly (XXXI) – Item 73—“Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment”; WHO’s Response to Operative Paragraph 4 of A/RES/3453(XXX). 23 July 1976.

⁴⁸⁷ Howard-Jones N. Health and human rights. *World Health*. 1976;3-7.

⁴⁸⁸ UN General Assembly Res. 2919 (XXVII). Decade for Action to Combat Racism and Racial Discrimination. 15 Nov. 1972.

globe. In doing so, WHO sought to expand international policy to address racism as an underlying determinant of health and to develop reports specific to the implications of apartheid on human rights. Although previous WHO neglect in the development of the 1966 International Convention on the Elimination of All Forms of Racial Discrimination had denied this Convention an explicit codification of a right to health equity, WHO nevertheless sought to implement these general legal obligations by studying the health effects of racial discrimination in the exercise of “[t]he right to public health, medical care, social security and social services.”⁴⁸⁹

In addressing racial discrimination as a threat to health rights—engaging with the UN Decade for Action to Combat Racism and Racial Discrimination—WHO began a study on the health implications of apartheid. In May 1974, the Chairman and Vice-Chairman of the Special Committee on Apartheid were welcomed to WHO Headquarters to meet with Director-General Mahler and discuss underlying determinants of health in apartheid states. In September of that year, WHO reported on its progress in studying the public health effects of racial discrimination and apartheid, sending a representative to the International NGO Conference Against Apartheid and Colonialism in Africa.⁴⁹⁰ Thereafter completing its preliminary research based upon the feedback of nongovernmental organizations, WHO submitted to the Executive Board in 1975 its survey of Health Implications of Apartheid in South Africa. Framing the issue of apartheid as a violation of health rights, WHO’s study found that “[i]t is obvious that

⁴⁸⁹ United Nations. International Convention on the Elimination of All Forms of Racial Discrimination. art. 5(e)(iv). 7 Mar. 1966

⁴⁹⁰ A. Benyoussef. Note for the Records: Attendance of [sic] International NGO Conference Against Apartheid and Colonialism in Africa – Palais des Nations, Geneva, 2-5 September 1974. 9 Sept. 1974.

mental health and social well being are closely linked to the enjoyment of human rights as defined in the Universal Declaration of Human Rights” and that “[m]ost such rights are legally denied to the non white South African.”⁴⁹¹ In presenting this study to the Executive Board, the Director-General reiterated the study’s political conclusion that “the health situation of the groups discriminated against by the policy of apartheid will not likely improve as long as the policy exists.”

With the Executive Board’s January 1975 endorsement of the preliminary WHO study, the Director-General was requested to undertake a more comprehensive study of apartheid and to continue to “explore with other organizations of the United Nations system appropriate ways to ensure the success of the United Nations Decade for Action to Combat Racism and Racial Discrimination.”⁴⁹² In accordance with this authorization, WHO (1) transmitted its survey in March 1975 to the UN Special Committee Against Apartheid, (2) published an overview of its work on the effects of apartheid on underlying determinants of health in the July 1975 issue of *World Health*, and (3) assisted the Organization of African Unity beginning in 1976 to train health personnel, provide emergency medical supplies, and establish health infrastructures for newly independent African states.⁴⁹³ At the request of the UN Special Committee on Apartheid,⁴⁹⁴ WHO followed-up its 1975 report with a derivative 1977 study, *Apartheid and Mental Health*

⁴⁹¹ WHO. Preliminary Survey: Health Implications of Apartheid in South Africa. Jan. 1975.

⁴⁹² World Health Organization Executive Board. EB55/39. 1975.

⁴⁹³ Letter from WHO Division of Coordination Director S. Flache to UN Division of Human Rights Director M. Schreiber. CWO-4N64/180/5. 6 Dec. 1976.

⁴⁹⁴ Letter from WHO Division of Coordination Director S. Flache to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/180/5. 14 Apr. 1978.

Care, examining evidence of *de jure* and *de facto* human rights violations in the availability and quality of mental health care services and concluding that:

These conditions and policies, being a direct effect of apartheid in the health field, are inimical to the letter and spirit of the WHO Constitution which proclaims that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”⁴⁹⁵

As WHO continued these studies in a series of articles on racism⁴⁹⁶ and apartheid,⁴⁹⁷ the Director-General delivered a rights-based invocation before the August 1977 World Conference for Action Against Apartheid, noting the importance of international cooperation for the implementation of health rights and arguing that: “The social goals in the sphere of health cannot be attained without international co-operation. The world which we share and must learn to share equitably is a ‘global village,’ in which one’s responsibility for the social and moral values to which we subscribe does not end at one’s doorstep.”⁴⁹⁸ Culminating these studies on race-based health disparities in Africa, WHO presented a final report to the 1978 World Conference to Combat Racism and Racial Discrimination, and the Director-General commemorated the March 1978 International

⁴⁹⁵ World Health Organization. Apartheid and Mental Health Care. No. 311/77. Apr. 1977 (emphasis in original).

⁴⁹⁶ Gray T. *World Health*. July 1975.

⁴⁹⁷ Jablensky A. Racism, apartheid and mental health. *World Health*. Dec. 1977.

⁴⁹⁸ World Conference for Action Against Apartheid, Lagos, Nigeria, 22 – 26 Aug. 1977: Action Against Apartheid by Agencies within the United Nations System: Statements at the World Conference for Action Against Apartheid. At 10.

Day for the Elimination of Racial Discrimination by issuing a message condemning apartheid and racial discrimination as violations of the WHO Constitution. As institutional emphasis on the effects of racism on health rights made its way from the Secretariat to the World Health Assembly, decisive action was taken to suspend the WHO membership of South Africa and Rhodesia for “violating its [WHO’s] principles and whose official policy is based on racial discrimination.”⁴⁹⁹

iv. Disability

In the implementation of the 1975 Declaration on the Rights of Disabled Persons⁵⁰⁰—for which WHO had contributed language on health rights well beyond the 1971 Declaration on the Rights of Mentally Retarded Persons—WHO sought to assure that states would realize the new Declaration’s rights to medical, psychological and functional treatment for disabled persons, including medical and social rehabilitation. To set up collaborative studies to assist in the implementation of the rights of this Declaration, WHO established “collaborating centres” in a number of countries, budgeting close to \$1 million per annum to:

1. undertake surveys of the needs of disabled persons;
2. develop appropriate technology for the disabled;
3. develop a new information system on disability;
4. study the most effective ways by which disability in the productive age can be diminished;

⁴⁹⁹ World Health Assembly. Res. 17.50. 1978.

⁵⁰⁰ United National General Assembly. Res. 3447 (XXX). 9 Dec. 1975.

5. study the most effective methods of delivering disability services at the primary health care level.

When the UN Secretary-General summarized implementation of this Declaration in the 1978 World Social Report,⁵⁰¹ with the UN seeking to understand how the principles of the Declaration had been included in the work of specialized agencies,⁵⁰² WHO assured UN coordinators that the success of its collaborating centres, programmatic interventions, and reports on disability reflected the Organization's larger commitment and contribution to studying the issues of disability rights as underlying determinants of health.⁵⁰³ Moving forward from this, WHO would work closely with the UN Secretariat to outline steps to be taken by states to implement this Declaration during the 1981 International Year for Disabled Persons.

v. Child Nutrition

In the early-1970s, public health research made clear that the use of certain milk substitutes in developing countries, as an alternative to breastfeeding, was responsible for the malnutrition and death of a multitude of infants.⁵⁰⁴ Faced with an intransigent infant formula industry, several prominent nongovernmental organizations began to criticize the

⁵⁰¹ United National General Assembly. Res. 31/82.

⁵⁰² Letter from UN Social Development Branch Acting Assistant Director-in-Charge Evner Ergun to WHO Co-ordination with other Organizations Chief O.W. Christensen. 7 July 1977.

⁵⁰³ Letter from WHO Coordination with Other Organizations Chief O.W. Christensen to UN Social Development Brance Acting Assistant Director-in-Charge Evner Ergun. CWO-4N64/372/1. 13 Dec. 1977.

⁵⁰⁴ Plank SJ, Milanesi M. Infant feeding and infant mortality in rural Chile. *WHO Bulletin*. 1973;48(2): 203-210.

exploitative and harmful marketing practices of these corporations, putting pressure on WHO to commit itself to this issue.⁵⁰⁵ To advance this public health policy goal, WHO sought to employ human rights to encourage breastfeeding and discourage marketing of these milk substitutes, studying new regulatory frameworks for child nutrition at the intersection of the right to health and right to food. By 1974, the World Health Assembly had passed a resolution urging states to “review sales promotion activities on baby foods and to introduce appropriate remedial measures, including advertisement codes and legislation where necessary.”⁵⁰⁶ Given the WHO Secretariat’s leading role in addressing the issue as an independent interlocutor, several nongovernmental actors agreed with the infant formula industry that any implementation of international regulation would require WHO’s continuing leadership, creating an unusual arbitrator role for an international organization.⁵⁰⁷ Coming off its 1978 work to establish an Action Program on Essential Drugs to challenge the practices of pharmaceutical companies in the developing world and reduce the costs of essential drug imports, the WHO Secretariat worked with these conflicting interests in child nutrition to create an international regulatory framework grounded in the human rights obligations of commercial interests. By 1980, the World Health Assembly had authorized WHO to prepare a code of conduct for corporate responsibility,⁵⁰⁸ and in the following year, the World Health Assembly, over last-minute

⁵⁰⁵ Sikkink K. Codes of conduct for transnational corporations: The case of the WHO/UNICEF Code. *International Organization*. 1986;40(4):815-840.

⁵⁰⁶ World Health Assembly. Res. 27.43.

⁵⁰⁷ Sikkink K. Codes of conduct for transnational corporations: The case of the WHO/UNICEF Code. *International Organization*. 1986;40(4):815-840.

⁵⁰⁸ Feld WJ. *Multinational Corporations and U.N. Politics: The Quest for Codes of Conduct*. Pergamon: New York. 1980.

opposition from US and corporate interests,⁵⁰⁹ adopted the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes.⁵¹⁰

vi. Scientific & Technological Developments

Taking up its repeatedly postponed study on the Health Aspects of Human Rights in Light of Scientific & Technological Developments, part of the UN's longstanding study of the human rights implications of scientific and technological developments,⁵¹¹ WHO began in 1973 (a) to comment on drafts of Division of Human Rights documents relative to the right to health⁵¹² and (b) to develop an independent report from the perspective of health aspects of human rights.⁵¹³⁻⁵¹⁴ In considering these health aspects of human rights, WHO found assistance in this study from its nongovernmental partners, with WHO benefiting from participation in the October 1973 meeting of the World Medical Association (discussing problems of computers and confidentiality in medicine)⁵¹⁵ and the November 1973 Roundtable Symposium of CIOMS (devoted to

⁵⁰⁹ Starrels JM. *The World Health Organization: Resisting Third World Ideological Pressures*. Heritage Foundation: Washington; 1985.

⁵¹⁰ World Health Organization. *International Code of the Marketing of Breast-milk Substitutes*. WHA 34.22. WHO: Geneva. 1981.

⁵¹¹ Commission on Human Rights. Resolution 10 (XXVII). Human Rights and Scientific and Technological Developments. 1970.

⁵¹² Letter for WHO Programme Co-ordination Chief Michael R. Sacks to UN Division of Human Rights George Brand. SO214 (12-1-2). 18 Dec. 1973.

⁵¹³ Letter for WHO Programme Co-ordination Chief Michael R. Sacks to UN Division of Human Rights Director Marc Schreiber. SO214 (12-1-2). 10 Dec. 1973.

⁵¹⁴ Memorandum from WHO Liaison Office with United Nations Director Sacks to WHO Office of the Director-General. Commission on Human Rights. 5 Feb. 1974.

⁵¹⁵ WMA Resolution. 19 Oct. 1973.

medical ethics and human rights).⁵¹⁶ With its Chief Legal Officer participating in this latter meeting, WHO sought to use this CIOMS Roundtable “as a prelude to our contribution to the Commission on Human Rights,”⁵¹⁷ providing feedback on an early draft of WHO’s detailed and integrated report on human rights and scientific and technological developments in the health field. Given this external feedback, WHO program offices came together to prepare a complete draft in early 1974,⁵¹⁸ whereupon the Director-General sought to finalize this draft to meet WHO’s consecutive responsibilities before the Commission on Human Rights, UN General Assembly, WHO Executive Board, and World Health Assembly.⁵¹⁹ As WHO staff were replying to UN requests to review the UN Secretariat’s three non-health-related reports on the Impact of Scientific and Technological Developments on Economic, Social and Cultural Rights,⁵²⁰⁻⁵²² the WHO leadership met with the UN Division of Human Rights to finalize its own

⁵¹⁶ *Protection of Human Rights in the Light of Scientific and Technological Progress in Biology and Medicine*. Proceedings of a Round Table Conference Organized by CIOMS with the Assistance of Unesco and WHO. WHO Headquarters, Geneva, 14, 15, and 16 November 1973. Geneva: WHO. 1974.

⁵¹⁷ Memorandum from WHO PC Chief to WHO Director General. Resolution WHA 23.41 – Human Rights. N61/86/154(A). 23 Feb. 1973.

⁵¹⁸ Memorandum from WHO Legal Director and Programme Co-ordination Chief to WHO Chiefs of all Sections. Draft Document for Executive Board and United Nations on Human Rights. 27 June 1974.

⁵¹⁹ Memorandum from WHO PC Chief to WHO Director General. Resolution WHA 23.41 – Human Rights. N61/86/154(A). 23 Feb. 1973.

⁵²⁰ Commission on Human Rights. Human Rights and Scientific and Technological Developments. The Impact of Scientific and Technological Developments on Economic, Social and Cultural Rights: Report of the Secretary General. E/CN.4/1084. 15 Feb. 1972.

⁵²¹ Commission on Human Rights. Human Rights and Scientific and Technological Developments. The Impact of Scientific and Technological Developments on Economic, Social and Cultural Rights: Report of the Secretary General. E/CN.4/1115. 24 Jan. 1973.

report. In these WHO-UN meetings, beginning in October 1974,⁵²³ it was decided that WHO's report for the Secretary-General had reached such an expansive scope that it would be cross-applied to the UN General Assembly's related request to comment on the protection of populations against social and material inequalities resulting from the use of scientific and technological developments⁵²⁴ and to WHO's consultations on previous reports by the Division of Human Rights.⁵²⁵

WHO's final 1975 report, *Health Aspects of Human Rights in the Light of Scientific and Technological Development*, covers a wide range of topics at the intersection of health technology and human rights, including chapters on the beginning of life (artificial termination of pregnancy, newborns with congenital defects, the use of human fetuses for research), reproduction (sterilization, castration, contraception, preventive medicine in genetic disorders, and artificial insemination), human experimentation (informed consent, therapeutic trials, publication of experimentation results), death, organ transplantation, computerized medical records, psychosurgery, environmental protection, and compulsory measures for health protection. Overlying the entire discussion, the WHO report begins with a chapter on "health as a human right." Through this introductory chapter, WHO presents both "what benefits and what parallel

⁵²² Commission on Human Rights. *Human Rights and Scientific and Technological Developments. The Impact of Scientific and Technological Developments on Economic, Social and Cultural Rights: Report of the Secretary General.* E/CN.4/1141. 28 Dec. 1973.

⁵²³ WHO CWO R.J. Anderson. Note for the File. 4N64/445/2. 15 Oct. 1974.

⁵²⁴ United Nations General Assembly. Resolution 3150 (XXVIII). *Use of Scientific and Technological Developments in the Interests of Peace and Social Development.* A/RES/3150 (XXVIII). 21 Jan. 1974.

⁵²⁵ Telegram from WHO Programme Co-ordination Chief Flache to WHO UN Liaison Malafatopoulos. 4N64/445/2. 5 Nov. 1974.

potential risks new developments may entail as far as the right to health,” considering “the exact significance of this right, what it involves, and what is its true perspective.” Reinterpreting the WHO Constitution to assure a comprehensive system of social insurance, WHO found collective public health obligations in the right to health, laying out a communitarian human rights ethic by which there exist “positive aspects for which the State and the community have a duty to ensure that the individual citizen benefits, but those rights may entail negative elements in that the individual citizen has the duty to limit his rights for the benefit of the community.” Given this overview and outline of relevant topics, WHO’s report concludes that “[t]he right to health presents negative as well as positive aspects,” with this negative conception framing public health measures in human rights terms, including “the duty of the citizen to submit himself to a number of requirements, as for example immunization or other compulsory measures, in order to prevent the right to health of other citizens being endangered.”

With the January 1975 approval of this report by the Executive Board, finding that “the right of every human being to the enjoyment of the highest attainable standard of health, as laid down in the WHO Constitution, can best be ensured under conditions of continuing scientific and technological progress,”⁵²⁶ the WHO Secretariat would embark on future studies for the Commission on Human Rights concerning scientific and technological developments related to economic and social development.⁵²⁷ Marking this

⁵²⁶ World Health Organization. Executive Board. Health Aspects of Human Rights in the Light of Scientific and Technological Developments. EB55.R65. 31 Jan. 1975.

⁵²⁷ Memorandum from WHO CWO Chief M.R. Sacks and WHO LEG Director F. Gutteridge to WHO COR Director and WHO Deputy Director-General. Letter to Secretary-General of United Nations Transmitting Resolution EB55.R65 on Health Aspects of Human Rights. 4N64/445/2. 5 Feb. 1975.

shift, WHO Director-General Mahler submitted the Executive Board's resolution and WHO report to the UN Secretary-General, expressing his personal commitment to human rights cooperation: "I wish to assure you that I look forward to an even closer collaboration with the United Nations and other specialized agencies...for the successful accomplishment of this broad matter of concern to the individual and to the community."⁵²⁸

With the Executive Board's approval "to continue the studies suggested in the report,"⁵²⁹ WHO sought in early 1975 to regain its leadership role in future collaborative studies of health rights, reaching out first to the UN Division of Human Rights and other specialized agencies to organize an informal joint meeting to discuss the future needs of the Commission on Human Rights.⁵³⁰⁻⁵³¹ In accordance with the UN General Assembly's invitation "to consider the preparation of recommendations concerning international standards,"⁵³² WHO also reached out to national experts for assistance, with the Director-General pointing out that: (1) "health is a fundamental human right," (2) WHO "has a role to play in human rights," and (3) "future contributions to the United Nations should

⁵²⁸ Letter from WHO Director-General H. Mahler to UN Secretary-General. 4N64/445/2. 18 Feb. 1975.

⁵²⁹ World Health Organization. Executive Board. Health Aspects of Human Rights in the Light of Scientific and Technological Developments. EB55.R65. 31 Jan. 1975.

⁵³⁰ Letter from WHO Co-ordination with Other Organizations Chief Michael R. Sacks to UN Division of Human Rights Director Marc Schreiber. G/SO 214 (12-1-2). 27 Feb. 1975.

⁵³¹ E.g., Letter from WHO Director-General M. Mahler to UNESCO Director-General Amadou Mahtar M'Bow. 4 Mar. 1975.

⁵³² United Nations General Assembly. Resolution 3268(XXIX). 10 Dec. 1974.

reflect the experience of Member States.”⁵³³⁻⁵³⁴ Finally, as the WHO Secretariat began to study these human rights issues for the first time—working feverishly to prepare a report on international standards for the UN General Assembly’s 1975 Session—WHO sought assistance from its nongovernmental partners, particularly the World Medical Association and CIOMS, “in developing new approaches to studies in the area of human rights.”⁵³⁵

As the Commission on Human Rights moved in 1975 to create a rights-based framework to balance state concerns for public health with individual liberties, WHO submitted a detailed legal memorandum to assist the Commission’s appointed Special Rapporteur in her study on “The Individual’s Duties to the Community and the Limitations on Human Rights and Freedoms under Article 29 of the Universal Declaration of Human Rights.”⁵³⁶ With this memorandum originating out the WHO’s newly engaged legal office (renamed the Office of Constitutional and Legal Matters), WHO provided legal justification for state derogations from individual rights for the

⁵³³ Letter from WHO Director-General H. Mahler to multiple states. C.L.5.1975. 13 Mar. 1975.

⁵³⁴ E.g., Letter from Republic of Cyprus Ministry of Health to WHO Director-General H. Mahler. M.H.354/75/II. 7 Apr. 1975; Letter from Nigeria Federal Ministry of Health to WHO Director-General H. Mahler. MH.1054/S.111/T/131. 28 Apr. 1975; Letter from Principauté de Monaco Service des Relations Extérieures Ministre d’Etat to WHO Director-General H. Mahler. OMS/CL.5.1975. 6 May 1975. Letter from Republica de Venezuela Ministerio de Sanidad y Asistencia Social to WHO Director-General H. Mahler. SI-921-75. 5 May 1975.

⁵³⁵ Letter from WHO Director-General H. Mahler to multiple nongovernmental organizations. 4N64/445/2. 13 Mar. 1975.

⁵³⁶ ECOSOC Sub-Commission on Prevention of Discrimination and Protection of Minorities. Res. 9 (XXVII). The Individual’s Duties to the Community and the Limitations on Human Rights and Freedoms Under Article 29 of the Universal Declaration of Human Rights. 21 Aug. 1974.

public's health, outlining individual obligations (1) to submit to health examinations and vaccinations, (2) to notify health authorities of communicable disease exposure, and (3) to undergo examinations, treatments, surveillance, isolation or hospitalization. In specifying this human rights basis for public health, the legal staff interpreted the Preamble of the WHO Constitution expansively, finding in WHO's definition of health that "the role of the Organization extends into the realm of social medicine and into such specific fields as mental health, public health, education, nutrition, housing, maternal and child health and welfare."⁵³⁷ To support WHO's legal legitimacy in continued inter-agency standard-setting for public health, extending WHO involvement through the 1982 final report of the Special Rapporteur,⁵³⁸ WHO's legal staff referenced and provided the Special Rapporteur with copies of WHO's legislative standards (including the International Health Regulations and the International Digest of Health Legislation) and legal analyses (on national legislation, comparative studies of public health regulations, and jurisprudence challenging national and international public health authority).

In the midst of these studies, the UN Secretary-General moved in April 1975 to draft his final report pursuant to the UN General Assembly's 1968 resolution on "Human Rights and Scientific and Technological Developments" – a report on "the balance which should be established between scientific and technological progress and the intellectual,

⁵³⁷ Letter from WHO Constitutional and Legal Matters Chief Claude-Henri Vignes to UN Division of Human Rights Deputy Director Erica Irene Daes. 4N64/372/1. 19 Sept. 1975.

⁵³⁸ The Individual's Duties to the Community and the Limitations on Human Rights and Freedoms under Article 29 of the Universal Declaration of Human Rights, report of the Special Rapporteur Erica-Irene Daes, UN Doc. E/CN.4/Sub.2/432/Rev.2. 1982.

spiritual, cultural and moral advancement of humanity.”⁵³⁹ To accommodate its various human rights commitments related to scientific and technological developments, WHO staff met with a staff member of the Division of Human Rights in May 1975, whereupon it was agreed that WHO would produce (1) a short summary on the benefits to human rights resulting from developments in science and technology for the UN Secretariat’s report to the General Assembly on the effects of scientific and technological developments on social and material inequalities and (2) a full report to the 1976 session of the Commission on Human Rights on the benefits of science and technology in raising standard of living to facilitate the enjoyment of underlying determinants of health, and as such, the realization of the right to health.⁵⁴⁰ Thereafter participating in UN meetings to finalize the UN Secretary-General’s report on the balance between technological progress and health, WHO’s seminal involvement would result in a UN chapter focused on the positive human rights implications of technology on health – “the uses to which modern science and technology may be put in the interest of promoting human rights.” Recomending a Declaration on Human Rights and Scientific and Technological Developments,⁵⁴¹ these meetings would—for the first time—frame the positive uses of new biological and medical discoveries. Based on WHO’s initiative, these positive

⁵³⁹ United Nations General Assembly. Res. 2450 (XXIII). Human Rights and Scientific and Technological Developments. 19 Dec. 1968. ¶1(d).

⁵⁴⁰ WHO Co-ordination with Other Organizations RJ Anderson. Note for the Record. 4N64/445/2. 27 May 1975.

⁵⁴¹ Letter from UN Division of Human Rights Officer-in-charge George Brand to WHO Deputy Director-General Thomas A. Lambo. G/SO 214 (12-1-5). 26 Sept. 1975 (attaching The Balance Which Should Be Established Between Scientific and Technological Progress and the Intellectual, Spiritual, Cultural and Moral Advancement of Humanity. Statement by the Group of Consultants).

effects of science and technology on health would be incorporated in (1) the UN Secretariat's 1975 Report on "the balance which should be established between scientific and technological progress and the intellectual, spiritual, cultural and moral advancement of humanity,"⁵⁴² and (2) the General Assembly's 1975 consideration of a draft declaration concerning "the use of scientific and technological progress in the interest of peace and for the benefit of mankind."⁵⁴³ In preparation for this latter debate, WHO presented on the importance of health rights at the 1975 session of the UN General Assembly.⁵⁴⁴⁻⁵⁴⁵

Following ideological debates and amendments on the relative emphasis of societal rights vis-à-vis individual rights—with the Soviet bloc and developing states joining in opposition to Western-style individual negative rights—the UN General Assembly in November 1975 adopted (95-0, 20 abstentions) the Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind.⁵⁴⁶ In the wake of this Declaration, WHO would develop its paper on the "positive effects of technological advances on health and human rights," completing the UN's series of papers (begun five years earlier) concerning the impact of science and

⁵⁴² United Nations. The balance which should be established between scientific and technological progress and the intellectual, spiritual, cultural and moral advancement of humanity. E/CN.4/1199 and Add.1. 1975.

⁵⁴³ United Nations General Assembly. The use of scientific and technological progress in the interest of peace and for the benefit of mankind. A/C.3/L.2144. 1975.

⁵⁴⁴ Memorandum from WHO Liaison Office with United Nations Director to WHO Office of the Director-General. UN General Assembly (XXX) – Third Committee Item 69. Human Rights and Scientific and Technological Developments. 28 Oct. 1975.

⁵⁴⁵ Health aspects of human rights. *WHO Chronicle*. 1976;30(9):347-359.

⁵⁴⁶ UNGA. Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind. Res. 3384 (XXX). 10 Nov. 1975.

technology on the range of human rights codified in the UDHR.⁵⁴⁷ As the Commission on Human Rights continued debates on the risks and benefits of science and technology on human rights, the WHO Secretariat would assure that the benefits of science and technology on health rights would not be forgotten, resulting in detailed support for the realization of health through the UN's 1979 Conference on Science and Technology for Development and the UN's 1982 General Assembly resolution concluding its program on Human Rights and Scientific and Technological Developments.⁵⁴⁸

c. Education

While these studies on the implementation of health rights were taking place at the governmental and international levels, WHO came to appreciate the role of human rights education in advancing health rights discourse at a grassroots level and in facilitating the realization of the right to health through public scrutiny of national policies. To do so, WHO would support human rights education for health practitioners and scholarly analyses of the right to health to enable the progression and implementation of rights-based health programming.

This education initiative began with an academic investigation of the role of international law in the context of social and economic development planning, with the United Nations University suggesting a formal WHO study in 1976 on the nature and

⁵⁴⁷ Letter from UN Division of Human Rights Officer-in-Charge George Brand to WHO Co-ordination with other Organizations Chief Michael R. Sacks. G/SO 214 (12-1-2). 10 Nov. 1975.

⁵⁴⁸ United Nations General Assembly. Resolution 36/56. Human Rights and Scientific and Technological Developments. A/RES/36/56. 18 Jan. 1982.

impact of international action toward the realization of the human right to health.⁵⁴⁹

Expanding on this suggestion in February 1977 discussions with the UN Division of Human Rights, WHO embarked on a coordinated effort with UNESCO to create model programs for teaching human rights and medical ethics in schools of medical sciences.⁵⁵⁰

Although WHO had previously cooperated with UNESCO on its 1974 recommendation concerning Education for International Understanding, Co-operation and Peace and Education Relating to Human Rights and Fundamental Freedoms—successfully inserting language on underlying determinants of health and declaring that education “must necessarily be of an interdisciplinary nature [and] should relate to such problems as . . .

the fight for a better quality of life and the highest attainable standard of health”⁵⁵¹—

WHO had not previously engaged in the development of human rights education for health practitioners. To promote this teaching, the two specialized agencies worked with the International Institute of Human Rights (a nongovernmental French organization providing independent expertise on human rights) to develop a questionnaire to “estimate the need in schools and in faculties of medical sciences for the teaching of human rights

⁵⁴⁹ Letter from United Nations Social Defence Research Institute Director Peider König to WHO Assistant Director General Thomas A. Lambo. UNSDRI 204. 24 Nov. 1976.

⁵⁵⁰ Memorandum from WHO HMD Director T. Fülöp to WHO CWO Chief. Division of Human Rights and Peace; UNESCO. 2 Feb. 1977.

⁵⁵¹ WHO Division of Health Manpower Development Director T. Fülöp. Report on Attendance at a Meeting of a Special Committee of Governmental Experts to Examine the draft recommendation concerning Education for International Understanding, Co-operation and Peace and Education Relating to Human Rights and Fundamental Freedoms. UNESCO, Paris, 29 April – 9 May 1974. 10 May 1974 (enclosing UNESCO. Special Committee of Governmental Experts to Examine the Draft Recommendation concerning Education for International Understanding, Co-operation and Peace and Education relating to Human Rights and Fundamental Freedoms).

and medical ethics.”⁵⁵² When UNESCO brought in an external consultant to complete this study in 1979,⁵⁵³ WHO thoughtfully supported the development of this joint recommendation, working through its legal office to assist the UNESCO consultant in developing a functional training document sensitive to “internationally oriented” bioethics concerns (rather than simply a summary of the burgeoning bioethics literature in North America and Western Europe).⁵⁵⁴ When UNESCO presented its human rights discussion document, including within it a two-page discussion of teaching on the right to health,⁵⁵⁵ this report received the 1980 support of an ad hoc group established across WHO divisions. While Director-General Mahler sought to avoid official sponsorship of any developed manual on “Physicians and Human Rights”—politically hesitant to put WHO’s imprimatur on value judgments pertaining to contentious social issues without a mandate from the World Health Assembly⁵⁵⁶⁻⁵⁵⁸—WHO nevertheless supported

⁵⁵² Letter from UNESCO Division of Human Rights and Peace Director Karel Vasak to WHO Division of Health Manpower Development Director Fulop. SS/HR/77/234/VS. 6 May 1977.

⁵⁵³ Letter from Universite de Franche-Comte Besançon Professor Jean-Marie Becet to WHO Director-General Halfdan Mahler. 28 Dec. 1979.

⁵⁵⁴ WHO HLE S.S. Fluss. Note for the Record: Confidential. Meeting with Mr. A.H. Zarb (formerly Director of the Legal Office in WHO) and Professor Maurice Torrelli (Institut du Droit de la Paix et du Développement, University of Nice) on 9 June 1980. N63/372/10. Undated.

⁵⁵⁵ Torelli M. *Le Medecin et les Droits de L'homme*. Paris: Berger-Levrault; 1980.

⁵⁵⁶ Memorandum from WHO HMD Director T. Fülöp to WHO Office for the Director-General. Teaching of Human Rights to Health Workers. Collaboration UNESCO/OMS Concernant L’enseignement des Droits de L’homme aux Personnels de Sante. E3/372/9. 27 Aug. 1980 (handwritten note by WHO Director-General H. Mahler).

⁵⁵⁷ Memorandum from WHO LEG H.J. Schlenzka to WHO Office of the Director-General. Teaching of Human Rights to Health Workers. E3/372/9. 28 Aug. 1980.

UNESCO's efforts in an educational capacity, creating guidelines on teaching methodologies in human rights⁵⁵⁹ and establishing official collaborations with CIOMS and the short-lived International Medical Commission for Health and Human Rights⁵⁶⁰ as the UNESCO consultant finalized his study.⁵⁶¹

This education initiative in health rights would reach its climax in a July 1978 workshop specific to the right to health, seeking through this workshop to facilitate progressive human rights discourses to reflect a shift from a “public health science era” (1950-1975) to a “political health science era” (1975-2000).⁵⁶² Setting the stage for revitalized discussion on a human right to health, the Hague Academy of International Law worked with the United Nations University to sponsor this Workshop on the Right to Health as a Human Right. As an explicitly interdisciplinary workshop, this three-day symposium set out to analyze the essential underlying determinants of health inherent in the right to health, with WHO staff seeking to burnish their leadership credentials in health rights as a capstone to a decade’s work employing the rhetorical mantle of human rights to further WHO’s public health agenda. Setting the stage for this legal discussion of health rights, the Director of the UN Division of Human Rights questioned whether international standards that enshrine the right to health are “adequately responsive to new

⁵⁵⁸ Memorandum from WHO SCR Secretary John F. Dunne to WHO Deputy Director-General T.A. Lambo. Teaching of Human Rights to Health Workers. 4 Sept. 1980.

⁵⁵⁹ Memorandum from WHO EPL/HMD J.-J. Guibert to WHO Ad hoc Group Members. Coordination with UNESCO in the Field of Human Rights. N63/372/10. 4 Dec. 1980.

⁵⁶⁰ Meyer-Lie A, Enals M, Mac Dermot N. Preparatory Meeting of Medical Personnel Concerned with Health and Human Rights. Geneva, 16-17 September 1980.

⁵⁶¹ Torrelli M. *Le Médecin et Les Droits de L'homme*. Paris: Berger-Levrault; 1983.

⁵⁶² Barton WL. Signpost to a new health era. Alma-Ata. *World Health*. July 1979: 5.

issues which have arisen affecting the right to health.⁵⁶³ Following this UN contribution, there were presentations from, *inter alios*, two members of the WHO Secretariat, one presentation outlining WHO efforts to implement the right to health at the national level⁵⁶⁴ and a second discussing WHO coordination in international affairs to realize the right to health and achieve its Health for All strategy for underlying determinants of health.⁵⁶⁵

Given the momentum for health rights coming out of these educational initiatives, with health rights shifting from a right to medicine to a “right to certain conditions for health,”⁵⁶⁶ there was growing agreement that WHO had the constitutional authority and human rights legitimacy to elaborate international legal obligations for underlying determinants of health, with an understanding that international law would benefit from the inclusion of the definition of health rights from the WHO Constitution.⁵⁶⁷ At the pinnacle of this advocated WHO authority for redefining international health law, WHO

⁵⁶³ van Boven TC. The right to health: Paper submitted by the United Nations Division of Human Rights. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. Sijthoff & Noordhoff: Alphen aan den Rijn, The Netherlands. 1979. 54-72: 55.

⁵⁶⁴ Sédeuilh M. Le droit à santé. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. 101-111. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979.

⁵⁶⁵ Vigne C. Droit à la santé et coordination. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. 304-311. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff. 1979.

⁵⁶⁶ Resume des debats – Summing up. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. 124-153. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff. 1979: 149.

⁵⁶⁷ Roscam Abbing HDC. *International Organizations in Europe and the Right to Health Care*. Deventer, The Netherlands: Kluwer; 1979: 129.

manifested its heightened role in coordinating international norm development for health rights.

2. Human Rights Development – WHO Incorporates Health in the International Treaty Framework

As WHO sought to develop new norms to advance health rights, it would influence the expansion of these rights in law, working with UN bodies to incorporate international legal language that would expand the normative development of health rights in accordance with health discourse on underlying determinants of health.

a. Women's Rights

WHO renewed its cooperation with the ECOSOC Commission on the Status of Women in March 1972, with WHO's Division of Maternal and Child Health pressing the WHO leadership to advance reproductive health discourses in interregional seminars on the status of women, framing these efforts through a preliminary paper on "Health, Status of Women and Family Planning."⁵⁶⁸ As the Commission on the Status of Women moved thereafter to consider the Protection of Women and Children in Emergency and Armed Conflict in the Struggle for Peace, Self-determination, National Liberation and Independence in June 1972,⁵⁶⁹ WHO followed upon its preliminary paper on women's health with a detailed memorandum on "Health Protection in Emergency with Special

⁵⁶⁸ World Health Organization. Note for the Record. Meeting with Representatives of ECOSOC Commission on the Status of Women. Geneva, 2 March 1972. 4N64/372/2. 8 Mar. 1972.

⁵⁶⁹ ECOSOC. Resolution 1687 (LII). 2 June 1972.

Reference to the Condition of Women and Children,” expanding its analysis on underlying determinants of women’s health:

medical factors in an emergency cannot be dealt with in isolation from the social services and public utilities – water supply, other environmental sanitation measures, and communication and transport.⁵⁷⁰

Given this expanding technical assistance in health care and underlying determinants of health, the Commission on the Status of Women came to recognize WHO as a valuable technical partner in considering the health vulnerabilities particular to women and a ambitious normative partner in developing human rights for women’s health.

In 1972, five years after the adoption of the Declaration on Discrimination Against Women (which largely skirted health issues) and four years after the introduction of ECOSOC’s reporting system on the implementation of the Declaration (to which WHO did not contribute) the Commission on the Status of Women sought to prepare a binding human rights treaty to give normative force to the provisions of the Declaration. As the Commission on the Status of Women began to consider treaty proposals to eliminate discrimination against women,⁵⁷¹ WHO would transition from technical assistance to human rights development with the 1974 articulation of a Draft Convention on the Elimination of All Forms of Discrimination Against Women. Working across its various divisions—led by the Division of Maternal and Child Health with input from the

⁵⁷⁰ Letter from WHO Division of Co-ordination Director A. Bellerive to UN Assistant Secretary-General for Social and Humanitarian Matters Helvi Sipilä. 4N64/372/1. 17 May 1973 (enclosing “Health Protection in Emergency with Special Reference to the Condition of Women and Children”).

⁵⁷¹ ECOSOC. Commission on the Status of Women. Resolution 1 (XXV).

Legal Director⁵⁷²—WHO proposed detailed comments on several of the underlying determinants of health contained in the Draft Convention, discussing World Health Assembly positions on family planning, highlighting areas of *de jure* and *de facto* gender equality in access to health services, and suggesting the addition of an article specific to reproductive health care:

In view of the special vulnerability of mothers and infants and in order to safeguard the health and promote the welfare of mothers, States Parties shall undertake to provide progressively free and easily available health care to mothers and future mothers. Such health care should comprise family planning and care during the ante- and post-natal periods and during confinement.⁵⁷³

To encourage greater incorporation of a woman's right to health in international legal development during the UN's 1975 International Women's Year, the WHO Secretariat (1) placed the status of women's rights on the world health agenda, inviting the UN Secretary-General of the International Women's Year to draft an article in *World Health*,⁵⁷⁴ and (2) placed the status of women's health on the international human rights agenda, participating in the World Conference of the International Women's Year, out of which the World Plan of Action called upon governments to ensure "improved access to

⁵⁷² Memorandum from WHO LEG Director to WHO CWO Chief. Status of Women. 4N64/372/2. 25 Aug. 1975.

⁵⁷³ Letter from WHO Division of Co-ordination Director S. Flache to UN Promotion of Equality of Men and Women Branch Officer-in-charge Sol Nahon. CWO-4N64/372/2. 21 Oct. 1975.

⁵⁷⁴ Sipilä H. Half of humanity. *World Health*. 1975;Jan.:3.

health services, better nutrition and other social services essential to the improvement of the condition of women...”⁵⁷⁵

Out of this World Plan of Action, the UN General Assembly adopted the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),⁵⁷⁶ describing it as an international bill of rights for women. Defining what constitutes discrimination against women, CEDAW codifies an agenda for national action to end such discrimination, and in doing so, clarified underlying determinants of maternal and reproductive health pursuant to the right to health. Moving beyond explicit state realization of the right to health—a right not mentioned in the 1967 Declaration on the Elimination of Discrimination Against Women—CEDAW recognizes a right to state ‘protection’ from the discriminatory acts of non-state actors against underlying determinants of women’s health, including “the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.”⁵⁷⁷ Given the health provisions of this new convention, WHO invited the former UN Secretary-General of the International Women’s Year (then promoted to UN Assistant Secretary-General) to write again in *World Health*, reflecting on the health goals of the UN Decade for Women (1976-1985), addressing “the special health needs of women,” discussing the future health role of ECOSOC’s Commission on the Status of Women, and

⁵⁷⁵ Declaration of Mexico on the Equality of Women and Their Contribution to Development and Peace. Adopted at the World Conference of the International Women’s Year, Mexico City, Mexico. 19 June-2 July 1975. E/CONF.66/34. 2 July 1975.

⁵⁷⁶ Convention on the Elimination of all Forms of Discrimination against Women. General Assembly Res. 34/180, U.N. Doc. A/34/46. 18 Dec. 1979.

⁵⁷⁷ Convention on the Elimination of all Forms of Discrimination against Women. General Assembly Res. 34/180, U.N. Doc. A/34/46. 18 Dec. 1979. art. 11(1).

explaining the translation of women's health rights from concept to World Plan of Action to international treaty.⁵⁷⁸

b. Rights of the Child

As the UN Division of Human Rights considered the rights of the child in 1976, it sought WHO's contribution for a UN report on "The Role of Youth in the Promotion and Protection of Human Rights." Although the WHO Secretariat had failed to attend the 1970 UN Seminar on the Role of Youth in the Promotion and Protection of Human Rights,⁵⁷⁹ WHO now took an interest in the health implications of this issue. With the WHO Secretariat entrusting the production of its report to its Office of Maternal and Child Health, WHO's lengthy contribution situated child health within the larger framework of WHO's interest in primary health care:

The active participation of young people in decision-making, from the primary to the national level, and in the implementation of programmes involving the health needs of youth, should be encouraged. The Organization advocates a broad-based community-centred service, with wide community and rural development responsibility: the basic premise being that youth would not be mere beneficiaries of these programmes but

⁵⁷⁸ Sipilä H. Women, health and human rights. *World Health*. 1979;July:6-9.

⁵⁷⁹ Memorandum from WHO CE Director to WHO EURO Regional Director. UN Seminar on the Role of Youth in the Promotion and Protection of Human Rights, Belgrade, 2-12 June 1970. 4N64/440/1. 24 Apr. 1970.

more so active contributors to health care and promotion of health in their families and communities.⁵⁸⁰

Beginning its contribution with the language of the right to health from the WHO Constitution, this response—while lacking in legal detail and seemingly misunderstanding the “role of youth” in this context (where the UN had referred to the role of the ‘concept of youth’ as a salient human rights consideration rather than the role to be played by youth in promoting and protecting human rights)—addressed underlying determinants of children’s health, transitioning between legal to moral obligations to address youth affected by poverty, rural underdevelopment, and urban migration.

When the Commission on Human Rights began in 1978 to develop concrete legal drafts for a Convention the Rights of the Child—seeking to codify the obligations of the 1959 UN Declaration on the Rights of the Child⁵⁸¹—WHO contributed to this treaty development, both within the draft Convention’s health provisions and in its consideration of underlying determinants of children’s health. Basing its authority on specific legally-binding references to child and maternal health in the WHO Constitution, the WHO Secretariat sought to buttress provisions for the healthy development of the child, with specific additions to ‘health’ and a ‘healthy environment’ in the draft Covenant’s Preamble and various substantive articles.⁵⁸² To do so, WHO assembled

⁵⁸⁰ Memorandum from WHO Maternal and Child Health Chief A. Petros-Barvazian to WHO CWO Chief O.W. Christensen. 4N64/372/1. 26 Oct. 1976 (enclosing The Role of Youth in the Promotion and Protection of Human Rights).

⁵⁸¹ United Nations. Declaration on the Rights of the Child. 14 U.N. GAOR Supp. (No. 16). U.N. Doc. A/4059. 1959.

⁵⁸² Memorandum from WHO Director, LEG C.H. Vignes to WHO CWO Chief O.W. Christensen. Review of Draft Convention on the Rights of the Child. 8 Aug. 1978.

comments from the Office of the Director-General, Legal Affairs, and technical program units dealing with issues of maternal and child health. Given extensive feedback from across WHO, its October 1978 response to the UN Secretary-General's request for views, observations, and suggestions from specialized agencies⁵⁸³ was harshly critical of the draft Covenant's lack of expansiveness in health rights, finding the draft to be "incomplete" and "weaker and less explicit than the Declaration."⁵⁸⁴ To rectify these weaknesses in the draft Convention's understanding and protection of children's health, WHO commented that a comprehensive treaty should include, among other clarifications, the following preambular paragraphs:

Reaffirming the principles laid down in the Constitution of the World Health Organization concerning the health of the child and the mother.

Bearing in mind that healthy development of the child is of basic importance and that the promotion of maternal and child health and welfare and the fostering of the ability of the child to live harmoniously in a changing total environment are necessary for the achievement of the purposes of this Convention.⁵⁸⁵

With WHO program staff taking active interest in investing the time and effort necessary to make a substantial contribution to the child's right to health, WHO sought thereafter to

⁵⁸³ Letter from UN Division of Human Rights Director Theo C. van Boven to WHO Director-General Halfdan Mahler. G/SO 214(28). 29 June 1978.

⁵⁸⁴ Letter from WHO Division of Coordination Director John L. Kilgeur to UN Division of Human Rights Director Theo V. van Boven. 31 Oct. 1978.

⁵⁸⁵ Letter from WHO Division of Coordination Director John L. Kilgeur to UN Division of Human Rights Director Theo V. van Boven. 31 Oct. 1978.

join further discussions with the Division of Human Rights and UNICEF,⁵⁸⁶ working through its Office of Maternal and Child Health to expand on its ideas⁵⁸⁷ until the UN's 1992 completion of the Convention on the Rights of the Child.⁵⁸⁸

3. An Evolving Right to Health – The Declaration of Alma Ata as a Rights-Based Approach to Realize WHO's Health for All Strategy

WHO's Health for All strategy would provide the backbone of its efforts to influence the normative development of the right to health, accommodating underlying determinants of health in international legal frameworks through the rights-based 1978 Declaration of Alma Ata. Viewing the shift 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."⁵⁸⁹ This rights-based argument for

⁵⁸⁶ Memorandum from WHO Acting Chief MCH S. Plaza de Echeverria to WHO Director COR. Comments by WHO on the Draft Convention on the Rights of the Child. 31 Oct. 1978.

⁵⁸⁷ E.g., Letter from WHO Maternal and Child Health Chief Mark A. Belsey to Defence for Children International Secretary General Per Tegmo. 13 Dec. 1984.

⁵⁸⁸ Convention on the Rights of the Child. Adopted 20 Nov. 1989. Entered into force 2 Sept. 1990.

⁵⁸⁹ Further thoughts on WHO's mission. Address of the Director-General to the 28th World Health Assembly. 1974, reprinted in *WHO Chronicle*. 1975;29(7):254.

underlying determinants of health was extended in 1975, whereupon 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 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 . . . 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.⁵⁹⁰

With the World Health Assembly approving of the Director-General's socio-economic direction in addressing underlying determinants of health, the WHO Secretariat extended this ambitious rights-based agenda outward in its 1976 paper on Primary Health Care and Rural Development, "supporting national planning of rural development aimed at the relief of poverty and the improvement of the quality of life."⁵⁹¹ Echoing the 'basic needs approach' of contemporaneous human rights scholarship, a movement seeking to meet the basic needs of a nation's poor through redistributive development,⁵⁹² this approach

⁵⁹⁰ Director-General report, OR 229, pp. 7-9.

⁵⁹¹ World Health Assembly. Resolution 29.74.

⁵⁹² E.g., Ghai DP, Khan AR, Lee ELH, Alftan T. *The Basic-Needs Approach to Development: Some Issues Regarding Concepts and Methodology*. Geneva: International Labour Office; 1977.

emphasized ‘primary health care’ as a means to realize underlying determinants of health and achieve WHO’s goal of ‘health for all.’⁵⁹³

a. New International Economic Order

In developing this rights-based approach, WHO considered its Health for All strategy to be integral to the achievement of regional and national efforts to realize the human right to development under a movement for a New International Economic Order.⁵⁹⁴ As with other areas of economic, social and cultural rights,⁵⁹⁵ calls for a New International Economic Order led to growing dissatisfaction with the limits of WHO’s health promotion agenda from both developed and developing states, with health scholars and advocates in the early-1970s seeking a WHO framework to address the underlying determinants of health implicated by a lack of economic development.⁵⁹⁶ Adopting the normative frameworks of this New International Economic Order, WHO sought to reprioritize its programming to place greater emphasis on poverty alleviation and health disparities between developed and developing countries. Where WHO had previously framed health programs as a means to achieve development,⁵⁹⁷ rather than development

⁵⁹³ Djukanovic V, Mach EP. Alternative Approaches to Meeting Basic Health Needs in Developing Countries: A Joint UNICEF/WHO Study. World Health Organization: Geneva. 1975.

⁵⁹⁴ Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/86/2. 28 Sept. 1979.

⁵⁹⁵ Cornwall A, Nyamu-Musembi C. Putting the “rights-based approach” to development into perspective. *Third World Q.* 2004;25:1415-1437.

⁵⁹⁶ Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SWA, Mansourian PB, Davies AM, Piel A, Sayers BM. *Understanding the Global Dimensions of Health*. New York: Springer. 2005;15-33.

as a means to achieve health, stark economic realities would recalibrate WHO policy in development discourse, advancing health as a right rather than a means to an economic end.

Addressing the human rights dimension of economic development inequalities, the Commission on Human Rights appointed a Special Rapporteur in 1969 to study the realization of economic, social and cultural rights. The Special Rapporteur's 1973 report, "The Widening Gap: A Study of the Realization of Economic, Social and Cultural Rights," devoted a full section to disparities in the right to the enjoyment of the highest attainable standard of physical and mental health, focusing on the importance of social security systems in realizing that right.⁵⁹⁸ Although WHO initially refused to provide comments or observations in consultations with the Special Rapporteur—arguing, consistent with its previous position on health rights, that the report contained "elements which go beyond WHO's programme or competence" in human rights and economic development⁵⁹⁹⁻⁶⁰⁰—this report would frame the role of human rights in addressing development inequalities, highlighting the importance of the right to health and WHO's limited programmes in developing and implementing that right.

⁵⁹⁷ World Health Organization. *The Second Ten Years of the World Health Organization*. World Health Organization: Geneva. 1968; ix.

⁵⁹⁸ Commission on Human Rights. The Widening Gap: A Study of the Realization of Economic, Social and Cultural Rights. By Manouchehr Ganji Special Rapporteur of the Commission on Human Rights. E/CN.4/1108. 5 Feb. 1973.

⁵⁹⁹ Letter from WHO Deputy Director-General P. Dorolle to UN Under-Secretary-General for Political and General Assembly Affairs. 4N64/372/1. 4 Oct. 1973.

⁶⁰⁰ World Health Organization. Note for the File. Meeting on 11 October 1973 with Mr. M. Ganji, Special Rapporteur, UN Commission on Human Rights. 4N64/372/1. 12 Oct. 1973.

Given this international human rights imperative for equity in development, scholars and practitioners began to focus on international economic arrangements that would assure health to all.

From this arose a movement for a New International Economic Order, its establishment declared in 1974 by the UN General Assembly, through which states aimed to fundamentally restructure trade, transnational corporations, aid, and international institutions to create:

(a) effective domestic control over natural resources; (b) regulation of the activities of multi-national corporations; (c) just and equitable prices for primary commodity and other exports of developing countries; (d) money and development finance reforms; (e) market access for products of developing countries; and (f) strengthening the science and technological capacity of developing countries.⁶⁰¹

To do so, this Declaration on the Establishment of a New International Economic Order set out twenty principles to, *inter alia*: reduce trade barriers against exports from developing countries; support stabilization of commodity prices and indexation of these prices to tie them to the cost of manufactured products produced by the developed countries; regulate transnational corporations, technology transfers, and nationalization of foreign property; increase overseas development assistance, including the development of

⁶⁰¹ United Nations General Assembly. Res. 3201. Declaration on the Establishment of a New International Economic Order. UN Doc. A/9559. 1 May 1974.

a food-aid program; democratically reform the IMF and World Bank; and renegotiate the debts of developing countries.⁶⁰²

The resulting 1974 Programme of Action—a set of urgent measures to be taken by the international community for developing states, crafted over the “collective acquiescence” of several developed states⁶⁰³—would advocate the strengthening of the role of the UN system in international economic cooperation for the acceleration of economic and social development. Based upon this, many African states—many of which had not ratified the ICESCR and had only recently become member states of WHO—drew WHO attention to the extent to which economic development influences both the scope of the right to health and the extent to which it is realized.⁶⁰⁴ Given this concern, the WHO Secretariat stayed apprised of state efforts to provide bilateral aid, emergency relief, and development assistance (including medical supplies and equipment) to developing countries,⁶⁰⁵ with Director-General Mahler recommending in November 1974 that WHO regional offices “ascertain the situation on the health front in the most seriously affected countries of their regions now qualified for assistance through

⁶⁰² Cornwall A, Nyamu-Musembi C. Putting the “rights-based approach” to development into perspective. *Third World Quarterly*. 2004;25:1415-1437.

⁶⁰³ Memorandum from WHO Liaison Office with United Nations Director to WHO COR Director A. Bellerive. Sixth Special Session of the General Assembly. 10 May 1974.

⁶⁰⁴ Eze OC. Right to health as a human right in Africa. In *The Right to Health as a Human Right: Workship, The Hague, 27-29 July 1978*. Sijthoff & Noordhoff: Alphen aan den Rijn, The Netherlands. 1979. 76-93.

⁶⁰⁵ Memorandum from WHO ACO Chief Ratko Pleic to WHO CWO Chief. UN Special Programme. N64/372/35. 23 Oct. 1974.

the Special Programme operations.⁶⁰⁶ With ECOSOC requesting that specialized agencies provide a mid-term review and appraisal of the International Development Strategy for the Second United Nations Development Decade, the WHO Secretariat saw an opportunity to become more heavily involved in development discourse, producing a report to discuss the benefits of development to the realization of health rights. This report would receive the support of the WHO Executive Board, which, noting the Declaration and Programme of Action for the Establishment of a New International Economic Order, authorized the Secretariat to continue to consider development and international economic cooperation in its health work.⁶⁰⁷

This authorization led WHO to collaborate with other UN agencies 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 a concern for deteriorating underlying determinants of health.⁶⁰⁸ With an economic crisis and energy crisis leading to increases in poverty and rising costs of natural resources in the mid-1970s, WHO would emphasize maldistributions of wealth in its human rights programming. Out of this arose policy discourses on a New International *Health Order*, explicitly linking health rights and development under WHO's international health planning.⁶⁰⁹⁻⁶¹⁰ Given an imperative for

⁶⁰⁶ Memorandum from WHO Director-General H. Maher to WHO Regional Directors. Programme of Action on the Establishment of a New International Economic Order: Special Programme. 13 Nov. 1974.

⁶⁰⁷ EB55.R61. Jan. 1975.

⁶⁰⁸ Djukanovic V, Mach EP. *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*. WHO: Geneva, Switzerland. 1975.

⁶⁰⁹ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979.

health equity under this New International Health Order, the Director General advocated that “this movement toward justice in health will require concerted action by the international community through the adoption of a global strategy for primary health care.”⁶¹¹ Grounded in concepts of justice and human rights, drawn from international treaties and the WHO Constitution, this socio-economic approach to health would form the basis of framing what WHO officials referred to as “the onset of the health revolution.”⁶¹²

In implementing this revolutionary vision through human rights, WHO sought to work with the UN, which was explicitly linking the New International Economic Order with the human right to development. With the Commission on Human Rights undertaking a proposed study in 1977 on “The International Dimensions of the Right to Development as a Human Right in Relation with Other Human Rights Based on International Cooperation, including the Right to Peace, Taking into Account the Requirements of the New International Economic Order and the Fundamental Human Needs,”⁶¹³⁻⁶¹⁴ the Division of Human Rights reached out to WHO for its contributions on the public health components of a right to development.⁶¹⁵ In responding to the UN’s request, WHO staff submitted several health documents on the right to development,

⁶¹⁰ Bélanger M. *Droit International de la Santé*. Economica: Paris, France. 1983.

⁶¹¹ Mahler H. Justice in health. *WHO Magazine*. May 1978. 3.

⁶¹² Lambo TA. Towards justice in health. *World Health*. 1979(July):2-5: 4.

⁶¹³ Commission on Human Rights Resolution 4 (XXXIII). 21 Feb. 1977.

⁶¹⁴ ECOSOC decision 329 (LXII). 13 May 1977.

⁶¹⁵ Letter from UN Division of Human Rights Director Theo C. van Boven to WHO Director-General Halfdan Mahler. G/SO 214(25). 27 June 1977.

grounding its collaboration on the human rights foundation of WHO's own health mandate:

Health as a basic human right, and as a vital element in the growth and development of individuals and thus as a prerequisite to development, should be considered in the proposed study. The long-term objective of the World Health Organization, which is "Health for all by the year 2000", is particularly relevant to the subject of the study. This objective has been defined as the enjoyment by all of a level of health that will be conducive to a high social and economic productivity. This is a basic human need and a fundamental human right, in keeping with the very principles of WHO's Constitution...⁶¹⁶

With WHO staff viewing the right to development as a path to increase acceptance of WHO's Health for All strategy, WHO would come to support the right to development as a path to realization of health rights, arguing that the operational implementation of primary health care systems "reach far beyond the health sector and thus are in full conformity with the comprehensive approach demanded by the precepts of NIEO [the New International Economic Order]."⁶¹⁷

b. Health for All

⁶¹⁶ Letter from WHO Coordination with other Organizations Chief O.W. Christensen to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/372/1. 30 Sept. 1977.

⁶¹⁷ Letter from WHO Director-General H. Mahler to UN Director-General for Development and International Economic Cooperation K.K.S. Dadzie. CWO-N64/372/35. 17 July 1979 (enclosing Statement of the World Health Organization in Contribution to the Report on Operational Activities for Development, Requested by the United Nations General Assembly in Resolution 33/201).

This “Health for All” strategy, officially defined by the World Health Assembly in 1977 and widely regarded as WHO’s “main thrust” for implementing the right to health,⁶¹⁸⁻⁶¹⁹ 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 socially and economically productive lives.”⁶²⁰ Focusing on the human rights obligations placed on WHO by its Constitution, nongovernmental organizations had come to advocate that WHO “acknowledge its duty to respond to the pressing ethical problems that are presented...by disparities in health between rich and poor people.”⁶²¹ With the World Health Assembly viewing the inequitable distribution of resources for health to be a political as well as technical failure, this Health for All strategy would examine health within the broader social and economic context of development,⁶²² finding that “[h]ealth is not a separate entity but an integral part of national development”⁶²³ and seeking the national and international redistributions that would lead to salubrious development policies pursuant to international human rights standards.⁶²⁴ In seeking to restructure economic and social

⁶¹⁸ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 14.

⁶¹⁹ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King’s College. London, England; 2001.

⁶²⁰ WHA 30.43. 1977. reprinted in WORLD HEALTH ORG., GLOBAL STRATEGY: HEALTH FOR ALL BY THE YEAR 2000 (1985).

⁶²¹ Gellhorn A. WHO and medical ethics. *WHO Chronicle*. 1977;31(5):194-195.

⁶²² Mower AG. *International Cooperation for Social Justice: Global and Regional Protection of Economic/Social Rights*. Westport, Connecticut: Greenwood Press; 1985.

⁶²³ Mahler H. Justice in health. *WHO Magazine*. May 1978. 3.

policies in accordance with the New International Economic Order, the Health for All strategy, emphasizing a need for national coordination between health and other sectors, provided a rights-based mission for WHO that had been wanting since the right to health was first proclaimed in the WHO Constitution.

To design the contours of this approach—moving the human right to health from vertical hospital-based technologies to horizontal public health systems—WHO convened the International Conference on Primary Health Care on September 6, 1978. This Conference, taking place in Alma Ata, USSR (now Almaty, Kazakhstan), sought to bring together interdisciplinary public health and development actors to address determinants of health outside of the control of health ministries. Returning to the UDHR’s promise of health rights under this ‘multisectoral’ or ‘intersectoral’ approach, WHO’s model approach to primary health care would take a synoptic view of health, seeking social justice in the distribution of health resources in line with the interconnectedness of human rights in realizing a right to health.

c. Declaration of Alma-Ata

With the Health for All strategy providing a rights-based vision reflective of public health 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. As WHO was participating for the first time in celebrations of

⁶²⁴ Gunn SWA. 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*. Torino, Italy. 20-21 May 1983.

the anniversary of the UDHR,⁶²⁵⁻⁶²⁶ the ICESCR was entering into force and WHO was preparing its first implementation report, and the Commission on Human Rights was adopting a draft Convention on the Rights of the Child,⁶²⁷ WHO and UNICEF came together in September 1978 to hold an international conference to frame a human rights perspective for achieving WHO's Health for All strategy.⁶²⁸ 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 Conference on Primary Health Care adopted the Declaration on Primary Health Care⁶²⁹ (a document that has come to be known as the 1978 Declaration of Alma-Ata), through which delegates memorialized their agreement that primary health care was the key to realizing underlying determinants of health. Through this Declaration, the WHO Secretariat created a framework to guide states in outlining the most feasible national policies necessary to realize health rights.

⁶²⁵ Human Rights Day 10 December, 1978: Thirtieth anniversary. *World Health*. 1978(December):16-17.

⁶²⁶ Halter S, Dilen H. The Universal Declaration of Human Rights: Thirty years on. 1978(July);3-4.

⁶²⁷ Commission on Human Rights. Question of a Convention on the Rights of the Child. Resolution 20 (XXXIV). 8 Mar. 1978.

⁶²⁸ Taylor C, Jolly R. The straw men of primary health care. *Social Science & Medicine*. 1988;26:971.

⁶²⁹ WHO. *Primary Health Care: Report of the International Conference of Primary Health Care Alma-Ata, USSR, September 6-12 1978*. World Health Organization: Geneva. 1978.

The Declaration of Alma-Ata focuses on primary health care, from which it derives 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 to maintain at every stage of their development in the spirit of self-reliance and self-determination.”⁶³⁰ Reaffirming the preambular language of the WHO Constitution, specifically that health “is a fundamental human right,” Article I of the Declaration outlines 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.” By specifying obligations under this right, the Declaration of Alma-Ata aims to promote a reorientation of national health development strategies to incorporate and fund primary health care programs. To achieve this governmental obligation in language similar to that of 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

⁶³⁰ Id.

health care is the key to attaining this target as part of development in the spirit of social justice.⁶³¹

Declaring health to be “a fundamental human right,” this declaratory language sought to achieve equity in health resources for primary health care. To attain this goal of “health for all by the year 2000,” the Declaration of Alma-Ata sought to rectify inequalities in health status both within and between states, encouraging states to work toward establishing a New International Economic Order and prioritizing disadvantaged groups in achieving “equity-oriented targets.” Noting the responsibility of governments for health equity, it found that primary health care—implemented through the national health system and through social and economic development—was a key to social justice.

Building from 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 Declaration of Alma-Ata’s holistic approach to basic needs, states expanded upon the provisions outlined in the ICESCR,⁶³² laying out specific rights-based governmental obligations for essential aspects of primary health care, including

⁶³¹ Id., § V.

⁶³² Grad FP, Feitshans IL. Article 12—Right to health. In Hannum H, Fischer DD (Eds.). *U.S. Ratification of the International Covenants on Human Rights*. American Society of International Law. Irvington-on-Hudson, New York: Transnational Publishers. 1993. 206-235.

- (1) education concerning prevailing health problems and the methods of preventing and controlling them;
- (2) promotion of food supply and proper nutrition;
- (3) an adequate supply of safe water and basic sanitation;
- (4) maternal and child health care, including family planning;
- (5) immunization against the major infectious diseases;
- (6) prevention and control of locally endemic diseases;
- (7) appropriate treatment of common diseases and injuries; and
- (8) the provision of essential medicines.⁶³³

Thus, despite an acknowledgement of the principle of progressive realization—giving flexibility to each state based upon its respective stage of development, in addition to political, social and technical factors⁶³⁴—the Declaration was intended to guide states in their application of the principle of progressive realization, promoting an emphasis on underlying determinants of health through primary health care rather than individual curative treatments.⁶³⁵ With flexibility in deciding national needs and priorities, these national plans and strategies would seek to ensure the protection of human rights, relying on WHO to support national efforts through technical assistance and budgetary advice in domestic planning, analysis, and monitoring.

⁶³³ WHO. *Primary Health Care: Report of the International Conference of Primary Health Care Alma-Ata, USSR, September 6-12 1978*. World Health Organization: Geneva. 1978, § VII.

⁶³⁴ Id.

⁶³⁵ Virginia Leary, Implementation of the International Covenant on Economic, Social and Cultural Rights – Day of General Discussion on the Right to Health, E/C.12/1993/WP.27, p.4.

To design these national plans, the Declaration of Alma Ata proclaimed a right of individual and collective participation in the planning and implementation of health care decisions.⁶³⁶ 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 public “participation” in health 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.”⁶³⁷ 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, 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:

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

⁶³⁶ WHO. *Primary Health Care: Report of the International Conference of Primary Health Care Alma-Ata, USSR, September 6-12 1978*. World Health Organization: Geneva. 1978.

⁶³⁷ Id.

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.⁶³⁸

While this legislative focus does not share the preeminence it held in previous international legal standards,⁶³⁹ this endorsement of the rule of law as a determinant of health was seen as vital to creating lasting institutions for primary health care.⁶⁴⁰

The Declaration that resulted from this Conference laid out a programmatic vision for realizing the right to health through primary health care. By laying out criteria for states in developing primary health care, and declaring these criteria to be human rights that would have priority over other national goals,⁶⁴¹ the Declaration of Alma-Ata presented a unifying framework for advancing public health under the mantle of the right to health. Subsequent to the Declaration of Alma-Ata, the Executive Board in January 1979 invited WHO member states to use the Declaration of Alma-Ata as the basis for formulating national policies in meeting the goals of Health for all by the Year 2000.⁶⁴²

⁶³⁸ Id., ¶ 125.

⁶³⁹ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁶⁴⁰ Fluss SS, Gutteride F. Some contributions of the World Health Organization to legislation. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. New York: Plenum Medical Book Co.; 1990.

⁶⁴¹ MacDonald TH. *Health, human rights and the United Nations: Inconsistent aims and inherent contradictions?*. Oxford: Radcliffe Publishing; 2008.

⁶⁴² WHO Executive Board. Resolution 21. EB63.R21. Jan. 1979.

Yet despite WHO's rediscovery of human rights development and implementation in the years leading up to the Declaration of Alma-Ata—with the application of these rediscovered frameworks in the Health for All strategy—WHO's past neglect of human rights created insurmountable weaknesses in the right to health—weaknesses that ultimately contributed to the failure of WHO's Health for All strategy and the abandonment of the Declaration of Alma-Ata.

IV. The Failure of Health Rights to Reflect Health Discourse

Where the human right to health did not reflect WHO's expansive definition of health—with human rights having narrowed from underlying determinants of health to medical care in the course of their evolution—the Health for All campaign would not find support in human rights frameworks. Without early WHO support for normative language on underlying determinants of health under the international legal regime of human rights, states could credibly find WHO's Health for All strategy, with a focus on social and economic development, to be beyond the purview of WHO's organizational mandate.⁶⁴³⁻⁶⁴⁴ Despite a set of complementary UN declarations on the processes of development,⁶⁴⁵ WHO never sought to codify its vision of salubrious development in international law. The International Conference on Primary Health Care had provided a

⁶⁴³ Mingst KA. The United States and the World Health Organization. In Karns MP, Mingst KA. *The United States and Multilateral Institutions: Patterns of Changing Instrumentality and Influence*. 205-230. Boston: Unwin Hyman. 1990.

⁶⁴⁴ Rajagopalan-Vorburger D. *World Health Organization and the Right to Health: A Legal Analysis of Its Interaction with Other Institutions*. Mémoire du Diplome d'études supérieures en relations internationals. Université de Genève. Geneva, Switzerland. 2002.

⁶⁴⁵ Paul JCN. The United Nations and the creation of an international law of development. *Harvard International Law Journal*. 1995;36:307-328.

unique discursive setting in Alma-Ata to elaborate norms for health rights and propose best practices for national policies, but in the absence of legal strictures, national governments could not be pressed to implement these rights through national public health policies. As a result of this lack of grounding in international human rights law, the obligations of the 1978 Declaration of Alma-Ata represented an illusory success for public health, with the Declaration's obligations incapable of both developing human rights obligations on states and implementing those obligations through primary health care.⁶⁴⁶

Although there existed a short-lived policy movement to implement equity-driven primary health care at the national level,⁶⁴⁷ these ethical movements toward distributive justice never took hold in health policy discourse, with these ephemeral frameworks melting away upon the slightest resistance from national governments. Even in the immediate aftermath of the Declaration of Alma-Ata, analysts were left to the conclusion that there existed no enforceable human right to health in international law.⁶⁴⁸ To the extent that such a right existed, it was thought to lack any concrete meaning without the evaluative indicators from which it could be implemented and enforced based upon

⁶⁴⁶ Thomas C, Weber M. The politics of global health governance: Whatever happened to "health for all by the year 2000"? *Global Governance*. 2004;10(2).

⁶⁴⁷ Nichols A. Ethics of the distribution of health care. *Journal of Family Practice*. 1981;12(3):533-538.

⁶⁴⁸ Battista ME. An enforceable human right to health: A new role for WHO. Sao Paulo Conference on the Law of the World, August 16-21. Washington: World Peace Through Law Center; 1981.

specific public health programs and outcomes.⁶⁴⁹ Although WHO developed a preliminary set of global indicators for assessing national compliance with the Health For All Strategy in 1981,⁶⁵⁰ this set of guidelines “was not a mandatory requirement and little political pressure has been applied to conform.”⁶⁵¹ In the absence of an institutionalized mandate for primary health care, WHO could not be successful in enforcing state policy development and in coordinating partnerships among the many agencies financing global health programs.⁶⁵²

In the absence of global health governance to promote WHO’s Health for All strategy, international health cooperation was sharply curtailed in the early 1980s,⁶⁵³ with many states moving away from their non-binding commitments under the Declaration of Alma-Ata.⁶⁵⁴ Accordingly, these states would come to reduce their budgetary support for

⁶⁴⁹ Mosher SA. *The Right to Health: A Comparative Study of the Health Care Systems of the United States, Sweden, and Cuba*. PhD Dissertation. University of Southern California. Los Angeles, California. 1980.

⁶⁵⁰ World Health Organization. *Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000*. Geneva: WHO; 1981.

⁶⁵¹ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King’s College. London, England; 2001: 110.

⁶⁵² Howard L. The evolution of bilateral and multilateral cooperation for health in developing countries. In Reich MR, Marui E (Eds.) *International Cooperation for Health: Problems, Prospects, and Priorities*. 332-357. Dover, Mass.: Auburn House; 1989.

⁶⁵³ Nakajima H. Priorities and opportunities for international cooperation: Experiences in the WHO Wester Pacific Region. In Reich MR, Marui E (Eds.) *International Cooperation for Health: Problems, Prospects, and Priorities*. 317-331. Dover, Mass.: Auburn House; 1989.

⁶⁵⁴ World Health Organization. *Progress in Primary Health Care: A Situation Report*. Geneva: WHO; 1983.

WHO Secretariat programs to assist national primary health care efforts,⁶⁵⁵ imperiling support for WHO's monitoring of policy reform and capacity-building in developing countries.⁶⁵⁶ Although select WHO regional offices attempted to develop national strategies for the Declaration of Alma-Ata, these regional efforts focused only on those states that already had developed and comprehensive health systems.⁶⁵⁷⁻⁶⁵⁸ Impoverished regions never had the opportunity to take up national policies under the Health for All strategy.⁶⁵⁹⁻⁶⁶⁰

When the situs of international legal frameworks moved from the UN system to international economic institutions at the end of the 1970s, there were no commensurate health rights in place to challenge these new institutional realities and prevent the collapse of WHO's Health For All strategy. As the World Bank began health sector lending in 1980 to promote individual responsibility for health and direct sector lending for medical services⁶⁶¹—a sharp reversal of the multisectoral primary health care

⁶⁵⁵ Dietrich P. WHO's budget 'crisis'. *Wall Street Journal*. 5 May 1988. 32.

⁶⁵⁶ Tarimo E, Webster EG. *Primary Health Care Concepts and Challenges in a Changing World: Alma-Ata Revisited*. Geneva: WHO. 1994.

⁶⁵⁷ Pinet G. The WHO European program of health legislation and the Health for All policy. *American Journal of Law and Medicine*. 1988;12:441-460.

⁶⁵⁸ E.g., WHO Regional Office for Europe. *Primary Healthcare – From Theory to Action. Report on a WHO Symposium, Kuopio (Finland), 30 November-3 December 1981*. Geneva: WHO; 1982.

⁶⁵⁹ *The African Response to the Global Philosophy of Action for Health*; 1981.

⁶⁶⁰ Mburu FM. Non-governemental organizations in the health field: Collaboration, integration and contrasting aims in Africa. *Social Science and Medicine*. 1989;292:591-597.

⁶⁶¹ World Bank. *Health Sector Policy Paper*. Washington: World Bank; 1980.

emphasis on underlying determinants of health under the Declaration of Alma-Ata—WHO had no alternative rights-based vision of primary health care codified in international law or domestic legislation. In the absence of such rights-based norms, WHO could not apply its Health for All strategy to influence the policies of international economic organizations.⁶⁶²

Without a binding human rights basis for its domestic and international health advocacy, WHO retreated back to the focus of its erstwhile nadir – the technical development of medical care services, implemented through a narrower focus on Selective Primary Health Care.⁶⁶³ This Selective Primary Health Care agenda, arising out of a 1979 Rockefeller Foundation meeting on health in the context of development, would create a parallel biomedical discourses to the Declaration of Alma-Ata's discourses on underlying determinants of health.⁶⁶⁴ These alternate discourses, focused on cost-effective vertical disease prevention and medical treatment services, would press for selective medical care rather than comprehensive primary health care in developing nations.⁶⁶⁵ While initially advocated as a utilitarian approach for achieving limited health care gains in states lacking the resources for comprehensive health reform, this medical approach came to be viewed as a legitimate substitute for any national health reforms and

⁶⁶² Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁶⁶³ Starrels JM. *The World Health Organization: Resisting Third World Ideological Pressures*. Heritage Foundation: Washington; 1985.

⁶⁶⁴ Walsh JA, Warren KS. Selective primary health care: An interim strategy for disease control in developing countries. *New England Journal of Medicine*. 1979;301(18):967-974.

⁶⁶⁵ Newell K. Selective primary health care: The counter revolution. *Social Science and Medicine*. 1988;26(9):903-906.

“had the effect of undermining the principles of primary health care.”⁶⁶⁶ Given the usurpation of global health governance by international economic institutions,⁶⁶⁷ institutions that supported Selective Primary Health Care with measurable indicators, the Declaration of Alma-Ata suffered from medical reductionism in its obligations. With an “emphasis on achieving tangible results instead of promoting change,”⁶⁶⁸ this framework for Selective Primary Health Care would come to be programatized under a limited GOBI (Growth-monitoring, Oral-rehydration, Breast-feeding, and Immunization) approach to global health development.⁶⁶⁹ With WHO co-opted into the limited approach of these international economic institutions, this medicalization of the right to health was incorporated into the World Health Assembly’s guidelines under WHO’s 1981 Global Strategy for Health for All by the Year 2000.⁶⁷⁰ Rather than addressing public health systems to alleviate underlying determinants of health, WHO’s focus shifted to ‘health services systems’ to address the provision of medical care,⁶⁷¹ reasserting a reliance on

⁶⁶⁶ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King’s College. London, England; 2001: 106.

⁶⁶⁷ Lee K, Collinson S, Walt G, Gilson L. Who should be doing what in international health: A confusion of mandates in the United Nations?. *British Medical Journal*. 1996;312:302-307.

⁶⁶⁸ Tejada de Rivero DA. Alma-Ata Revisited. *Perspectives in Health*. 2003;8:1-6:4.

⁶⁶⁹ Cueto M. The Origins of Primary Health Care and Selective Primary Health Care. *Am J Public Health* 2004; 94: 1864-1874.

⁶⁷⁰ World Health Organization. *Global Strategy for Health for All by the Year 2000*. World Health Organization: Geneva. 1981.

⁶⁷¹ Roemer MI. Analysis of health services systems – A general approach. In Pannenborg CO. et al. eds. *Reorienting Health Services: Application of a Systems Approach*. Plenum Press: New York. 1984. 47-60.

scientific progress and health technologies in solving medical harms, with these harms quantified in short-term morbidity and mortality figures.

In this resurrected focus on vertical health programming, through which international organizations again sought efficient health care expenditure as a means to economic growth, WHO greatly reduced its active participation in UN human rights activities, responding to UN requests for human rights information in 1980 and 1981 with technical details of WHO's health programs but otherwise neglecting any discussion of their human rights implications.⁶⁷² This general attitude is encapsulated in WHO's 1980 contribution to the Yearbook on Human Rights, wherein WHO reverts to its previous disclaimer of all institutional responsibility for human rights promotion: "The activities of the World Health Organization which could be of interest in the preparation of the Yearbook on Human Rights are relatively limited, as the Organization has no human rights procedures and programmes per se."⁶⁷³ Although WHO program staff continued to make reference to human rights in their health discourse throughout the early-1980s,⁶⁷⁴ the Secretariat leadership had backed away from the rights-based health policy. Without the development and implementation of human rights for health, states would return to a focus on medical services, developed without public participation and centered around

⁶⁷² E.g., Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director T.C. van Boven. CWO-4N64/372/1. 22 June 1981 (right to self-determination).

⁶⁷³ Letter from WHO Coordination with other Organizations Chief O.W. Christensen to UN Division of Human Rights Officer-in-Charge R. Prieto. 4N64/372/1. 30 Sept. 1980.

⁶⁷⁴ Gunn S.W.A., Emergency Relief Operations, World Health Organization. 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*. Tino, Italy. 20-21 May 1983.

hospital-based technologies for elites to the detriment of equitable primary health care systems for all.

V. Analysis – Where the Failure Lies

Formative events in the development and implementation of human rights impact contemporary human rights frameworks. Despite WHO's efforts to reclaim the legal standards of human rights for the public's health, rigid international legal paradigms leave human rights fixed on outmoded models of health, codified in weak international legal standards that cannot easily evolve. As highlighted in the chart below, international standards have narrowed the right to health from societal underlying determinants of health in the UDHR to individual medical care based on the ICESCR:

	WHO Constitution	UDHR	ICESCR	Declaration of Alma-Ata
Content of Right	Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.	...a standard of living adequate for the health and well-being of himself and of his family...	...highest attainable standard of health...	...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 ... 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.
State Obligation	Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.	...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.	(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.	Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. ... Primary health care is the key to attaining this target as part of development in the spirit of social justice.

Given these weakened health rights codified in the ICESCR, WHO has been laid low by the “highest attainable standard of health,” with rigid human rights standards limiting WHO’s expansive vision of a rights-based approach to health under the Declaration of Alma-Ata.

The 1948 WHO Constitution envisioned an expansive role for human rights protection and promotion in realizing the highest attainable standard of health, a state of complete health and not merely the absence of disease or infirmity. While UN policy-making bodies routinely discussed the development and implementation of human rights coordination in the 1950s and 1960s, often with the active participation of several specialized agencies, WHO remained absent throughout these coordination sessions.⁶⁷⁵ Given WHO’s (1) reluctance to politicize its work during the height of the Cold War, (2) incapacity to create legal frameworks for health rights, and (3) grounding in the conservative organizational culture of medical professionals, these vicissitudes in institutional leadership for human rights limited WHO’s ability to carry out its public health mission under its rights-based Health for All strategy.

The manner in which WHO framed health—as a limited technical challenge or a widespread social imperative—determined whether human rights would be seen as instrumental to the realization of health. Without seeing the need to establish legal frameworks to guide primary health care in the 1950s and 1960s, WHO could not bring states to accept their obligations to realize underlying determinants of health in the 1970s. That is, where WHO had focused on health as a set of functional problems rather than as

⁶⁷⁵ Samson KT. Human rights co-ordination within the UN system. In Alston P. *The United Nations and Human Rights: A Critical Appraisal*. 620-676. Oxford: Clarendon; 1992.

a human right, it failed to achieve both, undercutting its own practical health goals by denying them a grounding in human rights norms and discourse.

While it would be imprudent to place too much blame on the WHO Secretariat itself, as its budget and policies purport to represent the collective expression of its member states,⁶⁷⁶ it is clear in this historical context that the Secretariat leadership had dispositive organizational authority to set a rights-based agenda for the organization and to act independently in advancing human rights for health. With the Secretariat holding responsibility for the timing, content, and budget of issues brought before the Executive Board and World Health Assembly,⁶⁷⁷ the WHO Secretariat's agenda-setting authority—employed frequently in its early years to advance human rights policy—was never applied during crucial years of the development and implementation of human rights for health. Despite a constitutional mandate for leadership and coordination in health rights,⁶⁷⁸ the Office of the Director-General remained “cautious and stable,”⁶⁷⁹ failing to engage with the UN to advance health rights, to engage with states to influence government priorities, or to engage with international law to codify health priorities. In a world in which the only guarantor of human rights is the conscience of peoples, WHO had at its disposal many tools to arouse that conscience for health rights – including,

⁶⁷⁶ Gutteridge F. The World Health Organization: Its scope and achievements. *Temple Law Quarterly*. 1963;37(1):1-14.

⁶⁷⁷ Hoole FW. *Politics and Budgeting in the World Health Organization*. Bloomington, Indiana: Indiana University Press; 1976.

⁶⁷⁸ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁶⁷⁹ Godlee F. WHO in retreat: Is it losing its influence? *British Medical Journal*. 1994;309:1491-1495.

among other things, the development and implementation of international law; the study and recommendation of human rights obligations for health; the participation in human rights meetings and seminars; the dissemination of human rights information to health practitioners; and the cooperation with states in creating rights-based health policy. It failed to deploy health discourses to the realization of the right to health. Where other international organizations sought an expanding role for international human rights, WHO sought neither international legal frameworks for rights-based discourse nor health practitioner mobilization for rights-based advocacy.⁶⁸⁰⁻⁶⁸¹

This part analyzes the political, legal, and medical conditions correlated with WHO's failure to implement a rights-based approach to health, discussing the considerations that mediated WHO's translation of the health discourses of public health into the legal norms of human rights. Although the broad nature of these considerations limits any attribution of causation, the correlation of these ideational mechanisms with the normative development of the right to health provides rich qualitative evidence of the influences on WHO's behavior. With these correlations grouped under the broad headings of politics, law, and medicine, this part seeks to clarify these influences and explore how they impinged on WHO's development and implementation of the right to health.

⁶⁸⁰ Fidler DP. The future of the World Health Organization: What role for international law? *Vanderbilt Journal of Transnational Law*. 1998;31(5):1079-1126.

⁶⁸¹ Rajagopalan-Vorburger D. *World Health Organization and the Right to Health: A Legal Analysis of Its Interaction with Other Institutions*. Mémoire du Diplôme d'études supérieures en relations internationales. Université de Genève. Geneva, Switzerland. 2002.

A. Fear of Politicizing Health

“Medicine is a social science, and politics nothing but medicine at a larger scale.”

- Rudolf Virchow, 1848

Before WHO was established, commentators admonished those establishing global health governance at the end of the Second World War – “how can essential health work be prevented from suffering from the political changes of fortune of the present body, as happened with the League?”⁶⁸² Unlike the Health Office of the League of Nations, which was a technical section of a political organization, WHO was intended to be an autonomous organization free from the politics of international relations. To assure WHO’s freedom from political influence, it was noted at the time that:

One important distinction between the old Health Organization and the new WHO lies in the fact that the former was an integral section of a political body—the League of Nations—whereas WHO, following the example of the Pan American Sanitary Bureau, is a separate agency, an entity operating under its own constitution and merely affiliated with the United Nations. WHO thus can function directly as a technical body, without having to operate through the mazes of a lay political secretariat.⁶⁸³

⁶⁸² Health and the nations. *Lancet*. 1945;Aug. 11:177.

⁶⁸³ Russell PF. International preventive medicine. *Scientific Monthly*. 6 Dec. 1950. 393-400:397.

Despite this vision of institutional independence, nothing prevented political changes of fortune at WHO,⁶⁸⁴ with political imperatives quickly and permanently acting to the detriment of health rights. Buffeted by political forces, the WHO Secretariat allowed fleeting political forces to shape its development and implementation of human rights for health. Despite a vision of a universal organization dedicated to the non-political goal of health equity, “efforts to place health goals above power politics were pointedly rejected.”⁶⁸⁵ In many ways, WHO’s repeated proclamations of its non-political nature and its attempts to avoid political discourse only contributed to its failure to achieve political ends through human rights, denying it participation and influence in the political debates that shaped WHO policy.

1. Cold War Tensions & Medical Services

Undercutting the UDHR’s initial promise of universal human rights norms for health, the development of health rights would be hobbled almost immediately by the Cold War. Since the founding of the UN, great divisions had arisen within and among the former Allied Powers, with the March 1947 Truman Doctrine shifting U.S. policy toward the global containment of communism and marking the start of the Cold War. These changes would irreconcilably divide national foreign policies into two alternative ideological camps—Western capitalist democracies and Soviet communist regimes—with these divides impacting the conceptualization of human rights in international law and the implementation of public health through WHO. In translating the comprehensive

⁶⁸⁴ Pethybridge R. The influence of international politics on the activities of ‘non-political’ specialized agencies—a case study. *Political Studies*. 1965;13(2):247-51.

⁶⁸⁵ Lee K. *The World Health Organization*. London: Routledge; 2009. 24.

vision of the UDHR into legally-binding covenants, consensus on the development of human rights faltered largely along ideological and economic lines, with the two major superpowers (and their respective spheres of influence) split on both a belief in the substance of economic and social rights and the feasibility of realizing and implementing these rights. Scholars distinguished positive rights (economic, social and cultural) from negative rights (civil and political) on the basis of their respective (1) theoretical justifications, (2) normative elaboration, and (3) remedies. Questioning whether economic and social conditions were truly “rights” or merely “aspirational,” Western states advocated for the advancement of legal obligations only for civil and political rights, those classic civil liberties already protected by Western states’ national constitutions.⁶⁸⁶ Although these negative rights alone would form the basis of the 1948 draft International Covenant on Human Rights and the 1950 European Convention on Human Rights, the Soviet bloc would continue to proclaim positive rights as the basis for a just world, incorporating these rights in the draft International Covenant on Human Rights in 1950. Despite distinguishing these rights into different categories and separate covenants in 1952, many Western scholars continued to find that economic, social and cultural rights were of a category so fundamentally different from civil and political rights as not to be true human rights.⁶⁸⁷ As such, these scholars developed a hierarchical system for classifying rights, delineating first generation rights (civil and political) from those of the so-called second generation (economic, social and cultural)—to imply a

⁶⁸⁶ Alston P. The United Nations’ specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights, *Columbia Journal of Transnational Law*. 1979;18:79-118: 83 (citing 5 U.N. GAOR, C.3 (111th mtg.) 1-4, U.N. Doc. A/C.3/L.111 (1950)).

⁶⁸⁷ Cranston M. *What Are Human Rights?*. 1964.

devolution in rights—and pursuant to this hierarchy, held that the best way to achieve positive rights was to uphold negative rights, assuring the economic growth that would lead to “aspirational” social and economic benefits.

Given the positive state obligations inherent in a right to health, the Cold War posed inordinate challenges to the development of international co-operation for health rights. As described by a participant in the founding of the UN and WHO:

The World Health Organization came into being just at the time (1948) when the political honeymoon which the United Nations had enjoyed for a short period after the Second World War had definitely come to an end, and the “cold war” had started. It was of course a most unfortunate political climate for a newcomer which was supposed to act non-politically in the field of international health, but which was built and run by member governments.⁶⁸⁸

While the first meetings of the World Health Assembly would avoid political issues, the superpowers’ irreconcilable positions on social reforms and national health services would soon lay bare WHO’s claims to apolitical health policy and paralyze WHO’s human rights actions for underlying determinants of health.

Although there was great initial excitement that WHO would bind the entire world under a shared set of principles,⁶⁸⁹⁻⁶⁹⁰ there was also great suspicion from the

⁶⁸⁸ Evang K. *Health of Mankind: Ciba Foundation*. London: Churchill; 1967: 205.

⁶⁸⁹ History at Geneva. *Lancet*. 3 July 1948:17-18.

⁶⁹⁰ International health or world health?. *Lancet*. 14 Aug. 1948. 260.

United States that WHO would seek to advance a program of “socialized medicine.”⁶⁹¹

The United States posed the first challenge to WHO authority, before even the WHO Constitution came into force. In June 1948, WHO’s Interim Commission was faced with the long-delayed U.S. instrument of acceptance, which posed the first reservation to acceptance of the WHO Constitution, attesting that U.S. ratification did not commit it to enact any specific legislative program and reserving “its right to withdraw from the Organization on a one-year notice.”⁶⁹²⁻⁶⁹³ With the United States already an active member of the Pan American Sanitary Bureau, the only international health organization not yet subsumed within WHO, there was widespread international concern that the United States would leave WHO absent its reservations.⁶⁹⁴ Because neither reservations to acceptance nor withdrawals of membership were permitted by the language of the Constitution, this decision was deferred by the UN Secretary-General to the World Health Assembly. In the initial spirit of cooperation that pervaded the first World Health Assembly,⁶⁹⁵ states unanimously accepted the United States as a full member of WHO,⁶⁹⁶⁻⁶⁹⁷ giving the United States a unique legal status that would not be extended to

⁶⁹¹ This US Senate suspicion is contrasted with the enthusiastic support for WHO by the US Public Health Service. Letter for US Surgeon General Thomas Parran to International Office of Public Health Director Robert Pierret. 25 Jan. 1946.

⁶⁹² U.S. Code. Title 22, pages 4477-4478.

⁶⁹³ The United States reservation to the Constitution of the World Health Organization. *American Journal of International Law*. 1950;44:122-123.

⁶⁹⁴ Farley J. *To Case Out Disease: A History of the International Health Division of the Rockefeller Foundation*. New York: Oxford University Press; 2003.

⁶⁹⁵ Doull JA, Kramer M. The first World Health Assembly. *Public Health Reports*. 1948;63:1379-1403.

⁶⁹⁶ Official Records of WHO. 13, pages 77-80.

other states but implicitly endorsing the possibility of state withdrawal from the Organization.

Shortly thereafter, WHO was faced with the far-reaching consequences of this decision – with the Soviet Union abruptly withdrawing from WHO (along with the Ukrainian SSR and Byelorussia),⁶⁹⁸ followed in succession by withdrawals from Bulgaria, Romania, Albania, Czechoslovakia, Hungary, and Poland.⁶⁹⁹ The Soviet Union had long been hostile toward the Health Office of the League of Nations—with its perceived “Eurocentrism” viewed as an extension of the political and economic goals of imperial powers—and while its suspicions toward international health cooperation would be abated in the founding of WHO’s ambitious agenda for global health, this respite would be short-lived.⁷⁰⁰ With its February 1949 telegram beginning “we are not satisfied with the work of the WHO,” the Soviet Union argued that its withdrawal was forced by WHO’s “swollen administration,” lack of focus on underlying determinants of health, and limited technical assistance to the eastern European states.⁷⁰¹ Despite suspicion that these withdrawals were being used merely “as a vehicle for political attacks on the west

⁶⁹⁷ Telegram from World Health Assembly President Andrija Stampar to UN Secretary-General Trygve Lie. 3 July 1948.

⁶⁹⁸ U.S.S.R. leaves the World Health Organization. *Lancet*. 26 Feb. 1949. 355

⁶⁹⁹ Goodman NM. *International Health Organizations and Their Work*. J&A Churchill: London. 1952.

⁷⁰⁰ Osakwe C. *Participation of the Soviet Union in Universal International Organizations: A Political and Legal Analysis of Soviet Strategies and Aspirations Inside ILO, UNESCO and WHO*. Leiden: Sijthoff; 1972.

⁷⁰¹ Pethybridge R. The influence of international politics on the activities of ‘non-political’ specialized agencies—a case study. *Political Studies*. 1959;13(2):247-51.

and for propagandizing their own political and ideological beliefs,”⁷⁰² it was clear at the time that the Soviet Union—which had avoided the Technical Preparatory Committee to establish WHO, expressed concerns for its marginalization in health decision-making, and had long argued “that WHO should direct its efforts and organize its activities for the consolidation and development of national health services”⁷⁰³—was genuinely discouraged by the lack of medical supplies distributed to its war-ravaged populations and politically critical of WHO’s reluctance to address national health care administration for underlying determinants of health.⁷⁰⁴⁻⁷⁰⁵ As depicted contemporaneously by a US observer:

The main themes of Soviet criticism was that WHO’s work was superficial because it had neglected the root causes of disease. These causes, the Soviets explained, lay in the social and economic structure of various countries. In colonial areas, epidemics were caused by the poverty that resulted from imperialist exploitation. In more industrialized countries, disease problems were the natural outgrowth of capitalism. . . .

Hence, the USSR considered that WHO could achieve its aims only by

⁷⁰² Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43: 41

⁷⁰³ Quimby FH. 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. U.S. Govt. Print. Off.: Washington, DC; 1971: 27.

⁷⁰⁴ Jacobson HK. *The USSR and the UN’s Economic and Social Activities*. Notre Dame: University of Notre Dame Press. 1963.

⁷⁰⁵ Osakwe C. *Participation of the Soviet Union in Universal International Organizations: A Political and Legal Analysis of Soviet Strategies and Aspirations Inside ILO, UNESCO and WHO*. Leiden: Sijthoff; 1972.

promoting the gradual nationalization of health services, on the basis of the nationalization of important industries, after the Soviet model.

Throughout this argument, the Soviet bloc implied that all these deficiencies resulted from the domination of WHO by the western nations, particularly the United States.⁷⁰⁶

The Soviet bloc's withdrawal cut at the heart of the WHO mission—renouncing WHO in language drawn from the Organization's own Constitution—and represented a fundamental challenge to the entire WHO enterprise of apolitical cooperation for health.

Although the Soviet states had frequently lost debates in the World Health Assembly to the unified voting bloc of North, Central, and South America,⁷⁰⁷ their influence had moderated the dominance of free-market discourses for health rights. Without Soviet influence, socialized medicine would have no voice in World Health Assembly debates, preordaining a Western-driven medicalization of health in WHO human rights policy and limiting the WHO Secretariat's efforts to discuss national health care under a rights-based framework.⁷⁰⁸

With the United States and United Kingdom then shouldering over half of WHO's budget during the period of Soviet inactivity (compared to contributions of approximately 0.04% from developing states, many of which were nevertheless in arrears in these financial assessments), the United States demanded heavy compromises from WHO on

⁷⁰⁶ Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43: 41.

⁷⁰⁷ Emerson R, Claude I. The Soviet Union and the United Nations. *International Organization*. 1952;6:1-26.

⁷⁰⁸ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008.

medical care, underlying determinants of health, and social security issues in exchange for continued budgetary support.⁷⁰⁹ With the U.S. Congress having changed to Republican control in the 1946 midterm election, breaking up the “New Deal coalition” in U.S. liberal politics, the United States abandoned previous efforts to consider comprehensive health insurance similar to those of Western European nations⁷¹⁰⁻⁷¹¹ and made its aversion to “socialized medicine” a hallmark of its foreign policy in health. Flexing its authority through the control of WHO’s budget, the Soviet withdrawals gave the United States additional leverage within the funding-strapped WHO—leverage well beyond its single vote in the World Health Assembly—and the United States would use this authority to press the WHO Secretariat to emphasize “impact projects” over underlying determinants of health, using its politically-appointed representative to the Executive Board to set a medically-focused agenda for WHO.

Looking beyond WHO to meet its Cold War health goals, the US representative to the WHO Executive Board could legitimately threaten that “[t]he United States is prepared to push beyond the present reach of the WHO and is doing so through its bilateral programs.”⁷¹² Given its nationalistic goals in health diplomacy, the United

⁷⁰⁹ Jacobson HK. WHO: Medicine, regionalism, and managed politics. In Cox RW, Jacobson HK. *The Anatomy of Influence: Decision Making in International Organization*. 175-215. Yale University Press: New Haven; 1974.

⁷¹⁰ New York Academy of Medicine Committee on Medicine and the Changing Order. *Medicine in the Changing Order*. New York: Commonwealth Fund; 1947.

⁷¹¹ Bachman GW, Meriam L. *The Issue of Compulsory Health Insurance: A Study Prepared at the Request of Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare*. Washington, DC: Brookings Institution; 1948.

⁷¹² van Zile Hyde H. International health: Bilateral international health programs of the United States. *American Journal of Public Health*. 1951;41(12):1473-1476. 1473.

States' limited financial support for the multilateral funding of WHO is compared with the tens of millions of dollars that it was then providing in annual short-term bilateral health aid:

- (a) to friendly Western European governments under the Marshall Plan and Organization of Economic Recovery Cooperation, criticized at the time as “‘give-away’ health projects set up on an expensive, so-called emergency basis in various parts of the world;”⁷¹³
- (b) to Latin American republics through the Pan American Sanitary Bureau and the Organization of American States, extending health diplomacy and cooperative health programs developed in response to the attack on Pearl Harbor “as a measure that would aid in mobilizing the resources of the hemisphere for war and for the peace that would follow;”⁷¹⁴ and
- (c) to developing states under President Truman’s 1949 “Point IV Program,” providing technical assistance in health care as a fundamental part of U.S. foreign policy.⁷¹⁵

These U.S. bilateral operations became grounded in the Truman Doctrine for the containment of communism, reconceptualized for health in 1947 with “the open recognition, as a basis for national action, of the fact that communism breeds on filth,

⁷¹³ Russell PF. International preventive medicine. *Scientific Monthly*. 6 Dec. 1950. 393-400:397.

⁷¹⁴ van Zile Hyde H. International health: Bilateral international health programs of the United States. *American Journal of Public Health*. 1951;41(12):1473-1476. 1474.

⁷¹⁵ Hilleboe HE. What WHO means to us. *Public Health Reports*. 1955;70(11):1069-1074.

disease, and human misery.”⁷¹⁶ With U.S. government actors continuously framing health diplomacy “on unsatisfactory living conditions on which Communism feeds,” U.S. foreign policy would concern itself with vertical health services in developing nations imperiled by disease.⁷¹⁷ But with the United States seeking to use its health spending to influence minds as much as heal bodies—employing health resources as a means of “quieting unrest” in regions susceptible to communist influence⁷¹⁸—U.S. health spending would shift to focus on immediately impactful and highly visible medical interventions rather than long-term, “invisible” changes to underlying determinants of health.

Although the early leadership of the WHO Secretariat “did not embrace the era’s almost limitless medical optimism, this ‘magic bullet’ medicine, . . . the magic bullet approach was backed by a powerful group of Western-backed and Western-trained malariologists, and Cold War realities more or less demanded that ‘hearts and minds’ be captured by quick, Western-directed solutions to medical problems rather than by the slow grind of social and economic improvements.”⁷¹⁹ The United States continued to spend money on health through WHO, but it sought to do so in a medical fashion designed to advance its own foreign policy interests.⁷²⁰⁻⁷²¹ With Western nations

⁷¹⁶ van Zile Hyde H. International health: Bilateral international health programs of the United States. *American Journal of Public Health*. 1951;41(12):1473-1476. 1475.

⁷¹⁷ Thorp WL. New international progress in public health. *American Journal of Public Health*. 1950;40:1479-1485.1479.

⁷¹⁸ van Zile Hyde H. International health: Bilateral international health programs of the United States. *American Journal of Public Health*. 1951;41(12):1473-1476. 1476.

⁷¹⁹ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008: 3.

⁷²⁰ Thorp WL. New international progress in public health. *American Journal of Public Health*. 1950;40:1479-1485.

controlling budgetary priorities in the World Health Assembly, the WHO Secretariat—notwithstanding the outspoken advocacy of its staff for global approaches to social medicine—would have little discursive space to advocate for independent public health priorities.⁷²² As the United States successfully passed a 1953 budget counterproposal to slash WHO costs specific to Secretariat Headquarters and organizational meetings,⁷²³ an already enfeebled WHO Secretariat lost its remaining resources to take part in UN negotiations and to develop global health priorities through human rights. Although WHO’s subsequent Director-General sought to justify the Secretariat’s budgetary needs by emphasizing the importance of health conditions of the developing world to economic progress in the United States,⁷²⁴ this effort bore no additional U.S. appropriation to WHO’s budget. By 1955, WHO’s budget of \$9.5 million (less than one-sixth the contemporaneous public health budget of New York City) left it impotent to provide independent leadership for many of its public health goals. Paradigmatic of U.S. usurpation of WHO priorities during the Soviet hiatus, the United States would come to hold “Post-Assembly Technical Sessions,” with pharmaceutical companies sponsoring popular seminars following the World Health Assembly “to inform health officials of other countries about public health programs and principles in the United States and thus

⁷²¹ *Journal of the American Medical Association*. 1955;157(7):13-14.

⁷²² Brockington F. *World Health*. London: Churchill Lingstone; 1975.

⁷²³ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008.

⁷²⁴ Candau MG. WHO—prospects and opportunities: The road ahead. *American Journal of Public Health*. 1954;44(12):1499-1504.

increase their understanding of them and of the importance of United States participation in the World Health Organization.”⁷²⁵

With U.S. sway over a large number of countries in the World Health Assembly and unrivaled bilateral spending in health through the late 1960s,⁷²⁶ the United States could support its own medical agenda and effectively thwart any innovative approaches to health rights by the WHO Secretariat. In translating health discourses into human rights obligations, the WHO Secretariat was pressed to conform health rights to medical discourses for disease prevention and then to abandon human rights altogether. Given the U.S. focus on civil and political rights in order to diminish the Soviet focus on economic and social rights, the United States sought to limit opportunities by which it could be embarrassed by its nonadherence to health rights standards, discouraging WHO from addressing issues concerning health care organization (a large part of national health planning), limiting its role on social security matters merely to fact-finding and analysis, and diluting its authority in medical care for the poor relative to other, more pliable specialized agencies (e.g., UNICEF).⁷²⁷⁻⁷²⁸

⁷²⁵ WHO Post-Assembly Technical Sessions. *Public Health Reports*. 1955;70(11):1061–1092:1061.

⁷²⁶ Howard L. The evolution of bilateral and multilateral cooperation for health in developing countries. In Reich MR, Marui E (Eds.) *International Cooperation for Health: Problems, Prospects, and Priorities*. Dover, Mass.: Auburn House; 1989. 332-357.

⁷²⁷ Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43.

⁷²⁸ King PZ. Significance of UNICEF’s role in international child health activities. *American Journal of Public Health*. 1950;40(Feb.):177-182.

But with changes in Soviet leadership leading to the return of Soviet states beginning in 1955, WHO was pressed anew to consider social medicine within health rights.⁷²⁹ With WHO long having sought to assure the return of these states, the World Health Assembly had (1) worked carefully to assure that the People's Republic of China remained an active participant and (2) created a legal fiction by which the withdrawn Soviet and Eastern European states were referred to merely as “inactive members,”⁷³⁰ a nonpunitive fiction that succeeded in assisting the return of all the withdrawn states to full membership. As these states successively returned to WHO in the late 1950s and early 1960s, they brought with them a belief in the superiority of socialist medicine in meeting the health needs of newly-independent and developing states.⁷³¹ To translate its socialist health paradigm into WHO health policy toward developing states—focused on state obligations for the protection of health, provision of care, and sanitation of environments⁷³²⁻⁷³³—the Soviet Union sought to expand health rights from the voluntary establishment of individual medical services for curative care to the legal development of public health systems for underlying determinants of health. Although these efforts were

⁷²⁹ Rubinstein, AZ. *The Soviets in International Organizations: Changing Policy Toward Developing Countries, 1953-1963*. Princeton: Princeton University Press; 1964.

⁷³⁰ *Official Records of the WHO*. 1949;17:19,52.

⁷³¹ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008.

⁷³² Report on “The status of medical aid to the population and measures to improve the Public Health System in the USSR”. *Current Digest of the Soviet Press*. 1968;XX(26):15-20.

⁷³³ Osakwe C. *Participation of the Soviet Union in Universal International Organizations: A Political and Legal Analysis of Soviet Strategies and Aspirations Inside ILO, UNESCO and WHO*. Leiden: Sijthoff; 1972.

less fruitful in the late 1950s—with WHO spurning the Ukrainian SSR’s 1958 UN resolution to organize an International Public Health and Medical Research Year⁷³⁴—the Soviet states would continue to work through the 1960s to advance the cause of global health rights – through scores of WHO health seminars and training courses in the USSR, official WHO collaborations with Soviet medical research centers, donations to WHO stockpiles of Soviet vaccines, and participation in WHO Expert Panels by Soviet experts.⁷³⁵

With the election of a new Director-General in 1973, the Soviet Union saw in WHO a receptive partner to advance underlying determinants of health in human rights frameworks. In this reintroduction of Soviet thinking to the WHO Secretariat, Western scholars would lament that “in an era of cold war politics . . . public health has come to be subjected to cold war rhetorics[,] and this politics of public health has come to be centered on the international organization which was specifically created to promote international cooperation.”⁷³⁶ The site of WHO’s 1978 International Conference on Primary Health Care, in Alma-Ata, Kazakhstan, represented a prominent assertion of Soviet power in guiding the right to health. Steeped in the divide of the Cold War, this Soviet-led conference took pains to adopt the WHO definition of “complete” health, upholding government obligations to promote for each citizen a state of complete

⁷³⁴ Jacobson HK. *The USSR and the UN’s Economic and Social Activities*. Notre Dame: University of Notre Dame Press. 1963.

⁷³⁵ Osakwe C. *Participation of the Soviet Union in Universal International Organizations: A Political and Legal Analysis of Soviet Strategies and Aspirations Inside ILO, UNESCO and WHO*. Leiden: Sijthoff; 1972.

⁷³⁶ Id. at 115.

physical and mental health.⁷³⁷ While this thinking initially found support from U.S. policy makers during the fleeting days of U.S. support for economic, social and cultural rights,⁷³⁸ the 1980 election of President Ronald Reagan—and with it, a reflexive governmental opposition to WHO's regulatory activities—closed any opportunity for WHO to codify and implement the Declaration of Alma-Ata.⁷³⁹

2. WHO Decentralization & National Agendas

In considering the effect of national agendas on the promulgation of economic and social rights, early scholars of the UN warned that human rights “will necessarily produce inevitable conflicts with local law and the internal social and economic conditions in the member nations” and, as such, conflicts “will likely result in continuous international irritations and provocations instead of contributing to a better understanding between nations.”⁷⁴⁰ Although early leaders of the WHO Secretariat saw it as their mission to counter these nationalist tendencies to manipulate the UN to meet domestic political agendas,⁷⁴¹ subsequent leaders would not share this early WHO optimism for a strong Secretariat capable of implementing independent policy preferences in human

⁷³⁷ Litsios S. The long and difficult road to Alma-Ata: a personal reflection. *Int'l J Health Services*. 2002;32:709–32.

⁷³⁸ Bourne P. *New Directions in International Health Cooperation: A Report to the President*. Washington: U.S. Government Printing Office; 1978.

⁷³⁹ Mingst KA. The United States and the World Health Organization. In Karns MP, Mingst KA. *The United States and Multilateral Institutions: Patterns of Changing Instrumentality and Influence*. 205-230. Boston: Unwin Hyman; 1990.

⁷⁴⁰ Holman FE. International proposals affecting so-called human rights. *Law and Contemporary Problems*. 1949;14:488.

⁷⁴¹ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008.

rights. With states weakening the Secretariat policymaking apparatus through extensive decentralization to WHO regional offices, these regional offices, beholden to national agendas, would confound the development of global health governance for the right to health.

Through WHO's decentralization programme, a unique administrative configuration among UN specialized agencies,⁷⁴² the WHO Secretariat was weakened in developing and implementing international human rights for health. Framing this decentralization through regional health offices, article 44 of the WHO Constitution provides that:

- a. The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.
- b. The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.⁷⁴³

With authority for the health policies and services thereby delegated to WHO regional offices, each office had its decisions shaped by a distinct Regional Committee of member state delegates, meeting independently of the Secretariat in Geneva to plan WHO activities. Whereas this WHO regionalization would facilitate cooperative relations with national health authorities (ostensibly bringing WHO "nearer to the people" through

⁷⁴² Berkov R. *The World Health Organization: A Study in Decentralized International Administration*. Geneva: E. Droz; 1957.

⁷⁴³ *Constitution of the World Health Organization*. July 22, 1946. art. 44.

country and field offices⁷⁴⁴) and prevent the creation of independent regional health organizations (denying the universality necessary for WHO authority),⁷⁴⁵ the autonomy granted to these regional offices proved a hindrance to global health policy, with the Secretariat headquarters emasculated in the creation of universal standards and the design of national programs.⁷⁴⁶⁻⁷⁴⁷ This latter difficulty was recognized early in the decentralization process, with scholars noting that “the difficulty of maintaining a uniform policy is among the prime liabilities of a decentralized system, and that in the World Health Organization the problem in this regard has been recognized within the agency itself, both by national delegations and by secretariat members.”⁷⁴⁸ With human rights necessitating global leadership, WHO’s decentralized health structure proved inadequate to the establishment of inherently universal norms.

Although states developed the WHO Constitution to establish WHO as the least centralized of UN agencies⁷⁴⁹—with this decentralization to be manifested in the authorization of regional organizations similar to that already in existence in the Pan American Sanitary Bureau—this initial decision for regionalization (purported to be a

⁷⁴⁴ van Zile Hyde H. The nature of the World Health Organization. *Public Health Reports*. 1953;68(6):601-605. 602.

⁷⁴⁵ Calderwood HB. The WHO and regional organizations. *Temple Law Quarterly*. 1963;37(1):15-27.

⁷⁴⁶ Mani C. International health: Application of WHO programs and policies in a region. *American Journal of Public Health*. 1951;41:1469-1472.

⁷⁴⁷ Calderwood HB. The WHO and regional organizations. *Temple Law Quarterly*. 1963;37(1):15-27.

⁷⁴⁸ Berkov R. *The World Health Organization: A Study in Decentralized International Administration*. Geneva: E. Droz; 1957: 21-22.

⁷⁴⁹ *Constitution of the World Health Organization*. July 22, 1946. arts. 44-54.

means to meet geographically-specific public health challenges) did not come to fruition and specificity until the early-1950s. With the establishment of regional offices a matter of vociferous debate among state delegates (with regions differing sharply on this call for regionalization and focusing on which countries would be assigned to which regions), the WHO Secretariat initially sought to avoid this politically-charged decentralization of health authority. In particular, Director-General Chisholm was strongly opposed to the immediacy of establishing autonomous regions before the WHO Headquarters had fully established its central authority.⁷⁵⁰ Given this Secretariat opposition, the World Health Assembly agreed to establish regional offices only by the consent of the majority of member states in the region.⁷⁵¹ The final establishment and details of regionalization came to pass in 1951, largely at the insistence of the United States, which did not want to relinquish its longstanding health diplomacy through the Pan American Sanitary Bureau's work with Latin American health ministries. As explained by the Director of the Pan American Sanitary Bureau, Pan American regionalization was justified by the common bonds of its members, advancing the implausible rationale that the United States shared inseparable public health similarities with Latin America nations (but presumably not with Canada):

The six WHO Regions...vary widely in those climatic, ethnic, political, religious, cultural, economic, and epidemiological factors which influence the nature of regional health problems and the development of national

⁷⁵⁰ Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press. 2008.

⁷⁵¹ Calderwood HB. The WHO and regional organizations. *Temple Law Quarterly*. 1963;37(1):15-27.

health services, and determine the ease of international collaboration. The 22 nations and the almost equally numerous territories of the Americas have a common cultural heritage from a small section of Western Europe and have none of the deep-seated racial, religious, ideological, and territorial dissensions which make international collaboration so difficult in some of the Regions.⁷⁵²

Once these regionalization processes had been set into motion, the WHO Secretariat would gradually but predictably relinquish global authority in the ensuing years, with a WHO Assistant Director-General later lamenting that the prematurity of this decision “ensured that centralization did not become too firmly established.”⁷⁵³ In this decentralization process, six WHO regional offices were created—Southeast Asia, Eastern Mediterranean, Western Pacific, the Americas, Africa, and Europe—with these regional and country officers making up over two-thirds of Secretariat personnel.⁷⁵⁴ With the remaining work of the Secretariat divided among two substantive departments, Central Technical Services and Advisory Services to Governments, the WHO Secretariat retained little administrative coordination over health policy, with scholars commenting that WHO staff were losing “all responsibility for the operations which the Organization

⁷⁵² Soper FL. International health: Some aspects of the WHO's programs in the Americas. *American Journal of Public Health*. 1951;41:1464-1468.

⁷⁵³ Goodman NM. *International Health Organizations and Their Work*. London: J&A Churchill; 1952: 253-254.

⁷⁵⁴ Hoole FW. *Politics and Budgeting in the World Health Organization*. Bloomington, Indiana: Indiana University Press; 1976.

is conducting in their particular specialty – converting them into advisers without power of decision.”⁷⁵⁵

With the development and implementation of health policy relegated to regional offices, these regional offices—autonomous in many policy-making areas and increasingly disconnected from the Secretariat—came under the influence of national interests and regional blocs. Given the selection of Regional Directors by their respective Regional Board of member states (rather than the Executive Board, as empowered by the WHO Constitution),⁷⁵⁶ these directors would find themselves beholden not to WHO headquarters but to the priorities of regional powers – in the cases of poorer regions, to the priorities of their colonial powers. As criticized by WHO’s first Director-General, these WHO Regional Directors often directed poorer countries simply to adhere to developed country priorities in the development of national health services:

We have not yet found all the answers and it would be a very bold person indeed who would go into any underdeveloped country and say: “You should do as we do and then you will have no more troubles.” Yet occasionally this is the attitude that is taken towards some of the underdeveloped countries. When that does happen the people of those countries are very polite. In effect they say, “Oh yeah,” and let it go at that. They are far more willing to accept our peculiarities than we to

⁷⁵⁵ Berkov R. *The World Health Organization: A Study in Decentralized International Administration*. Geneva: E. Droz; 1957: 104.

⁷⁵⁶ Calderwood HB. The WHO and regional organizations. *Temple Law Quarterly*. 1963;37(1):15-27.

accept theirs, and they even try to understand our limitations and make allowances for us.⁷⁵⁷

Given this reprioritization of WHO staff and resources, the delegation of programming to regional offices shifted WHO from directing and coordinating international health to assisting governments in strengthening health services, providing assistance to each nation to deal with health issues of its government's (or its colonial administration's) choosing.⁷⁵⁸ As seen in the WHO Secretariat's failed 1952 efforts to create international health policy for family planning—with national blocs of Catholic states preventing WHO action and then relocating population concerns to the UN Division of Social Affairs—the WHO Secretariat was increasingly beholden to national priorities rather than public health imperatives.⁷⁵⁹ More pervasive in its regional influence, the United States—which provided a double assessment to WHO, funding the Pan American Sanitary Bureau separately from its contribution to the overall WHO budget—would meet monthly with the Pan American Sanitary Organization Director to develop programs based on US funds and apply this regional funding stream explicitly to fund vertical medical interventions over horizontal public health systems.⁷⁶⁰⁻⁷⁶¹

⁷⁵⁷ van Zile Hyde H. The nature of the World Health Organization. *Public Health Reports*. 1953;68(6):601-605. 602 (quoting Brock Chisholm).

⁷⁵⁸ Berkov R. *The World Health Organization: A Study in Decentralized International Administration*. Geneva: E. Droz; 1957.

⁷⁵⁹ Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SW, Mansourian PB, Davies AM, Piel A (Eds.). *Understanding the Global Dimensions of Health*. 15-33. New York: Springer. 2005.

⁷⁶⁰ Soper FL. International health: Some aspects of the WHO's programs in the Americas. *American Journal of Public Health*. 1951;41:1464-1468.

As a result of these political dynamics, WHO's regional programs in the 1950s and 1960s came to be indistinguishable from the fleeting bilateral health programs of Western states, focusing on highly-visible interventions in medicine rather than policies for underlying determinants of health. With this weakening of Headquarters-based coordination functions and the delegation of decision-making authority to the narrow purview of regional offices, the WHO Secretariat possessed scant authority to develop and implement universal human rights for health. Although regional human rights instruments were created, WHO regional offices took little part in these negotiations.⁷⁶² As a result, none of these regional instruments would be more progressive than international law in its elaboration of health rights,⁷⁶³ denying the right to health the "bubbling up" of norms from region to global that has been common to human rights evolution in other fields.⁷⁶⁴

With WHO's attempt to create a worldwide health policy framework in the Declaration of Alma-Ata, this universal rights-based vision quickly fell prey to WHO's decentralized authority and regional power dynamics. Regional implementation of the Declaration of Alma-Ata led to widely differing policy recommendations and militated against the planned universality of national indicators under WHO's Health for All

⁷⁶¹ van Zile Hyde H. International health: Bilateral international health programs of the United States. *American Journal of Public Health*. 1951;41(12):1473-1476.

⁷⁶² E.g., Roscam Abbing HDC. *International Organizations in Europe and the Right to Health Care*. Deventer, The Netherlands: Kluwer; 1979.

⁷⁶³ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 49.

⁷⁶⁴ Finnemore M, Sikkink K. International norm dynamics and political change. *International Organization*. 1998;52(4):887-917.

strategy.⁷⁶⁵ Rather than seeking the comprehensive primary health care reforms of the Health for All strategy, national political actors were more likely to implement only those aspects of health care most advantageous to their electoral position or visible to their constituents – e.g., hospital construction and medicine distribution.⁷⁶⁶ Because “it takes a long time to show results and because the benefits are not easily calculated,”⁷⁶⁷ primary health care had little resonance for state politicians.⁷⁶⁸ Where underlying determinants of health are, by definition, invisible due to the length of time for the interventions to achieve changes in public health indicators, state actors preferred the highly-visible “impact” interventions of medicine.

Thus, although the WHO Constitution granted expansive authority to the WHO Secretariat, the Secretariat rarely sought in its early years to exercise this authority to the detriment of national sovereignty.⁷⁶⁹ Instead, regional directors were given enormous autonomy in shaping policies within their respective regions, and state governments took advantage of their leverage over regional directors to construct policies supportive of medicine rather than underlying determinants of health. Although the Secretariat

⁷⁶⁵ World Health Organization. *Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000*. Geneva: WHO; 1981.

⁷⁶⁶ Rathwell T. Realities of Health for All by the Year 2000. *Social Science and Medicine*. 1992;35:541-547.

⁷⁶⁷ Salim E. Primary health care belongs in the mainstream of development. *World Health Forum*. 1988;9:307.

⁷⁶⁸ Van der Geest S, Speckmann JD, Streefland PH. Primary health care in a multi-level perspective: Towards a research agenda. *Social Science and Medicine*. 1990;30(9):1025-34.

⁷⁶⁹ Quimby FH. 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. Washington: U.S. Govt. Print. Off.; 1971.

Headquarters had ultimate authority to set regional policy—exercising this authority, for example, to create uniformity in administrative practices—it did not apply this authority to create policy in public health or human rights. Where the WHO Executive Board and World Health Assembly officially reviewed and approved all regional programs, they intervened in regional decisions only in extraordinary circumstances and only to amend budgetary allocations rather than substantive decisions.⁷⁷⁰ Given this expansive leeway, regional offices came to control the Headquarters itself, and where WHO saw rights-based public health regulation as infringing on state sovereignty, WHO preferred national persuasion and recommendation over international legal strictures, presenting itself to regions as a non-political organization devoid of ideological preference.⁷⁷¹

3. Developing Nations & a New International Health Order

When WHO would shift towards rights discourse in the 1970s, the rise of developing nations would press WHO to embrace human rights under a new right to development rather than the existing right to health. Without such a right to development codified by the United Nations or developed through international consensus, WHO would lack a basis in international law to pursue its rights-based agenda. Although there was growing international consensus throughout the 1970s that such a right existed, ambiguities as to its substance, beneficiaries, and implementation would prove fatal in applying a right to development framework to the Declaration of Alma-Ata.

⁷⁷⁰ Calderwood HB. The WHO and regional organizations. *Temple Law Quarterly*. 1963;37(1):15-27.

⁷⁷¹ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971.

As decolonization rapidly progressed throughout the world and the United Nations expanded several-fold, nascent member states—those that did not take part in the original drafting of the UDHR and subsequent covenants⁷⁷²—forced a reexamination of human rights to address global inequities.⁷⁷³ With the failure of the UN's First Development Decade (1960-1970), critical theory in economic discourse became formalized into a movement for a New International Economic Order. The concerns of this New International Economic Order—organized by the Non-Aligned Movement (or “Group of 77”), a loose grouping of states in Africa, Asia, and the Middle East that banded together to advance their interests against those of the two major superpowers⁷⁷⁴—centered on the volatility of commodity prices on the world market and a desire for an international economic system that would help moderate these inequitable effects.⁷⁷⁵ Among the systemic inequities in the global economic regime, there was a growing belief that international economic disadvantages had prevented developing states from creating the welfare policies of developed social democracies, infringing the rights of the entire nation. To these developing states, especially those most seriously affected by the financial and energy crises, it had become clear that the state itself could be the holder of moral and legal rights, aggregated rights of a nation that are distinct from the

⁷⁷² Chakravarti R. *Human Rights & the United Nations*. Calcutta, India: Progressive Publishers; 1958.

⁷⁷³ Prebisch R. *The Economic Development of Latin America and Its Principal Problems*. 1962.

⁷⁷⁴ Ishay MR. *The History of Human Rights: From Ancient Times to the Globalization Era*. 2004.

⁷⁷⁵ Gordon RE, Sylvester JH. Deconstructing development. *Wis Int'l L J* 2004; 22(1): 1-98.

sum of the individual rights of their peoples. Viewing traditional human rights frameworks as an extension of colonial domination, these developing states advanced so-called “solidarity rights” as a means of freeing states from the societal binds of “neocolonization.”⁷⁷⁶ With the ascendance of developing states in international institutions, these nations brought their demands for a collective ‘human right to development’ to a Special Session of the UN General Assembly in 1974,⁷⁷⁷⁻⁷⁷⁸ developing this human right to development pursuant to the New International Economic Order.

Applied to health, developing states sought to employ WHO to advance health equity through a right to development – first in medical technology transfers and subsequently in primary health care.⁷⁷⁹ Given the rising influence of these developing states within WHO, with developing nations proclaiming a right to development at the same time that WHO was creating its Health for All strategy,⁷⁸⁰ these developing states found that they could advance a focus on economic determinants of health by (1) voting

⁷⁷⁶ Howard R. Evaluating human rights in Africa: Some problems of implicit comparisons. *Human Rights Quarterly*. 1984;6:160-179.

⁷⁷⁷ UNGA Res. 3201. Declaration on the Establishment of a New International Economic Order. UN Doc. A/9559. 1 May 1974.

⁷⁷⁸ Gordon RE, Sylvester JH. Deconstructing development. *Wis Int'l L J* 2004; 22(1): 1-98.

⁷⁷⁹ Nakajima H. Priorities and opportunities for international cooperation: Experiences in the WHO Wester Pacific Region. In Reich MR, Marui E (Eds.) *International Cooperation for Health: Problems, Prospects, and Priorities*. Dover, Mass.: Auburn House; 1989. 317-331.

⁷⁸⁰ Jacobson HK. WHO: Medicine, regionalism, and managed politics. In Cox RW, Jacobson HK. *The Anatomy of Influence: Decision Making in International Organization*. Yale University Press: New Haven; 1974. 175-215.

in concert in the World Health Assembly, (2) enlarging the WHO Executive Board (from 18 to 31 state representatives) to increase developing country membership,⁷⁸¹ and (3) expanding proportional staff representation in the WHO Secretariat to accommodate developing state representatives.⁷⁸² Operating through the World Health Assembly, these developing states would be responsible for shifting the human rights basis of the WHO Secretariat, resolving in 1970 that “the right to health is a fundamental human right” and that one of the long-term objectives of WHO would be the attainment by all peoples of the highest possible level of health through:

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 [sic], 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.⁷⁸³

Beginning in 1975, WHO reoriented its programme budget for technical assistance and cooperation to accommodate a comprehensive rights-based approach to underlying determinants of health that would be reflective of the New International Economic Order.

⁷⁸¹ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971.

⁷⁸² Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979.

⁷⁸³ World Health Assembly. Resolution 23.61. 1970.

It is out of this process that a New International Health Order was born, with large numbers of small developing states outnumbering the few developed states to shift the WHO budget to meet the needs of the poor through economic development for health. With the support of these developing nations, the WHO Secretariat sought to advance human rights for health equity under its Health for All strategy.

However, with the basis of WHO's Health for All strategy to be found in the right to development—a right tethered to the neocolonization ideologies of Marxist labor economists⁷⁸⁴—this strategy would be faced with skepticism and hostility by Western capitalist powers.

Confronting an imbalance between voting power and financial responsibility, developed states organized themselves outside of WHO into the so-called “Geneva group,” using this group to press the leadership of the WHO Secretariat on budgetary and programming policies before debate reached the Executive Board or World Health Assembly.⁷⁸⁵ To further increase their political power outside of the WHO administrative structure, developed states created extrabudgetary commitments in order to tie funding to specific actions.⁷⁸⁶ Where the United States sought additional responsibilities for WHO, this was done through the establishment of generous voluntary funds to buttress limited core WHO allocations. Where these states could not implement

⁷⁸⁴ Chossudovsky M. Human rights, health, and capital accumulation in the Third World. *International Journal of Health Services*. 1979;9(1):61-75.

⁷⁸⁵ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971. 31.

⁷⁸⁶ Vaughan JP, Mogedal S, Walt G, Kruse S-E, Lee K, de Wilde K. WHO and the effects of extrabudgetary funds: Is the Organization donor driven? *Health Policy and Planning*. 1996;11(3):253-264.

their policy preferences through internal pressure or extrabudgetary commitments, there arose national preferences for bilateral assistance over multilateral organizations, further weakening the WHO Secretariat in directing global health governance under a right to health.⁷⁸⁷

Because the right to health was weakened from decades of WHO neglect, WHO opted to develop health rights through a novel right to development rather than a limited right to health. As such, the Declaration of Alma-Ata would draw on the New International Economic Order to place health in the broader economic context of development and to identify health within the context of national economic concerns. But by focusing its normative development and programmatic implementation of health rights within the framework of a right to development, hitching its health goals to a human right associated with Marxism and without precedent in the individual human rights movement, WHO was incapable of translating these political claims into legal rights. Given that the right to development and New International Economic Order were based on the power of votes rather than the strength of ideas, “consensus and a willingness to respect these instruments was clearly lacking.”⁷⁸⁸ With developing states unable even to advance a UN Declaration on the Right to Development until 1986, WHO’s Health for All strategy would operate under the language of human rights but do so without the obligations of international law.

⁷⁸⁷ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971.

⁷⁸⁸ Paul JCN. The United Nations and the creation of an international law of development. *Harvard International Law Journal*. 1995;36:307-328. 311.

Overall, in considering the political factors correlated with the failure of WHO's Health for All strategy, it becomes clear that public health is inherently political. While 'functionalist' scholars have thought that WHO's failures in international health policy have arisen out of its engagement in political advocacy under the Health for All campaign—to the detriment of technical assistance in medical matters and disease-specific eradication campaigns⁷⁸⁹—this history highlights that WHO's failure stemmed from not engaging consistently in political advocacy to meet its public health goals through human rights norms. Despite arguments that public health actors act apolitically, working expeditiously for the best interests of health, it has long been clear that “when either personal or governmental interests are at stake in permanent international agreements, professional medical people are often as political as their professional diplomatic counterparts are expected to be.”⁷⁹⁰ Early commentators foresaw this enlarged political role for WHO beyond that of its predecessor organizations, noting that “the broadened concept of world health which WHO has adopted, and the increased range and capacities of that Organization have projected world health into the arena of world politics at a number of points.”⁷⁹¹ Yet WHO long continued under the pretense that it was a non-political institution, masquerading in the technical cloak of its predecessor organizations. This feigned ignorance for the political ramifications of its

⁷⁸⁹ Siddiqi J. *World Health and World Politics: The World Health Organization and the UN System*. Columbus, South Carolina: University of South Carolina Press; 1995.

⁷⁹⁰ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971: 36.

⁷⁹¹ Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43: 36.

work left WHO without the political tools of human rights. Despite an effort by WHO to apply the Declaration of Alma-Ata to scrutinize domestic political considerations—advancing what scholars have interpreted as “post-Westphalian governance approach” in international public health policy⁷⁹²—this political transition was not based on a strong foundation of global health governance.⁷⁹³ As such, the political goals of WHO’s Health for All campaign were easily ignored by states, which had come to accept WHO’s early proclamations that such political governance of underlying determinants of health was outside the Organization’s competence.

B. Lack of Legal Capacity

“[T]he expansion and development of the field of public health rely on law. No single service or regulatory program of public health exists without authorization.”

– Frank Grad, 1990

Law is a fundamental determinant of global health. In reviewing international public health efforts leading up to the founding of WHO, scholars have concluded that “law has proved to be an effective instrument. Either in the form of international health conventions, international health regulations or national health statutes, law has consistently served mankind in its efforts to promote a healthier world.”⁷⁹⁴ With global

⁷⁹² Fidler DP. Fighting the axis of illness: HIV/AIDS, human rights, and U.S. foreign policy. *Harvard Human Rights Journal*. 2004;17:99-136. 112.

⁷⁹³ Werner D. *Where There Is No Doctor*. Berkeley: Hesperian; 1983.

⁷⁹⁴ Osakwe C. *Participation of the Soviet Union in Universal International Organizations: A Political and Legal Analysis of Soviet Strategies and Aspirations Inside ILO, UNESCO and WHO*. Leiden: Sijthoff; 1972: 102.

public health concerns having long proven fertile ground for effective international and national legal developments, most remarkably though international sanitary regulations extending back well over a century,⁷⁹⁵ WHO was endowed with expansive powers to shape law for underlying determinants of health. Notwithstanding these legal authorities in the WHO Constitution, the application of law for the public's health was neglected through the institutional evolution of WHO, with efforts to improve and standardize health systems accomplished through the hortatory efforts of recommendations rather than international or national law. With larger legal staffs and institutional emphasis on legal frameworks, other UN specialized agencies (ILO, UNESCO) and international organizations (the UN Environmental Program and International Maritime Organization) were essential to developing widespread consensus for international laws and establishing specific requirements for implementing those laws through domestic legislation.⁷⁹⁶ In comparison with the robust legal efforts of these other international agencies to achieve their respective organizational priorities, the abandonment of Health for All reflects WHO's failure to employ a legal implementation strategy in international and national law.

WHO's incapacity toward legal frameworks—never developing personnel devoted to human rights or incorporating its Legal Office in early rights-based communications with the UN—limited its contributions to the right to health.⁷⁹⁷ While

⁷⁹⁵ Barkhuus A. The dawn of international cooperation in medicine. *Ciba Symposia*. 1943;5(Oct):1554-1562.

⁷⁹⁶ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁷⁹⁷ Lakin A. The legal powers of the World Health Organization. *Medical Law International*. 1997;3:23-49.

WHO would become a “world clearinghouse” for public health information,⁷⁹⁸ these public health discourses were rarely translated into global health policy through law. With the individual medical approach to health not seen as necessitating legal implementation, where legislative frameworks were not required for selective curative treatments,⁷⁹⁹ this lack of legal foundation would prove detrimental when law became necessary to the codification and implementation of primary health care. Without robust legal obligations under human rights treaties, WHO’s past neglect of law would leave it without a legal basis from which to frame its approach to underlying determinants of health under the Health for All strategy. In crafting human rights for health *de novo*, cognizant of the novel ground it was charting, WHO nevertheless neglected to sustain these health discourses in law, with scholars subsequently finding that “at no time in this entire process of philosophical change [under the Health for All campaign] has there been any urgent or insistent demand for an appropriate legal framework.”⁸⁰⁰ With the rights-based obligations of the Declaration of Alma-Ata neither codified in international human rights law nor codified in national primary health care law, these obligations lacked the sustainability that only institutional legal frameworks could provide. Despite WHO’s full-hearted attempts to mainstream human rights in its health activities pursuant to its Health For All strategy, it was hobbled in these efforts by its inability to engage with the

⁷⁹⁸ van Zile Hyde H. The nature of the World Health Organization. *Public Health Reports*. 1953;68(6):601-605. 603.

⁷⁹⁹ Nájera E, Nájera P, Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379.

⁸⁰⁰ Id. at 364.

language of legal rights, develop standards under international law, or implement these standards in national legislation.

1. Legal Rights

WHO possesses invaluable technical expertise in public health matters, giving it preeminent legitimacy in developing public health standards and evaluating state health programs. However, WHO could not bind states meaningfully to achieve its Health for All strategy where it was not competent to frame these normative and evaluative processes pursuant to human rights frameworks. Without institutional legitimacy in human rights, WHO was not a meaningful actor in UN human rights development and national human rights implementation. As a result, human rights frameworks for health did not advance to encompass underlying determinants of health, regressing to the limited purview of medical care.

Although WHO initially sought to develop international medical law in the aftermath of the horrors of Nazi physicians during the Second World War and the Doctor's Trial at Nuremberg, both the WHO and UN Secretariat found this to be too monumental an undertaking for WHO. Specifically, the UN Secretary-General, in preliminary observations on an international medical tribunal, found the proposed WHO project too large to be accomplished given the Organization's limited legal staff, suggesting an inter-agency consultation for such a widespread undertaking.⁸⁰¹ When it came time for the UN to consider international medical law in the context of its 1969

⁸⁰¹ Letter from UN Secretary-General Dag Hammarskjold to WHO Director-General Marcolino Candau. SOA 317/07 (2) WHO. 24 Nov. 1954.

program on “Respect for Human Rights in Armed Conflicts,”⁸⁰² WHO noted that its technical focus precluded it from commenting on legal instruments, deferring to the World Medical Association and International Committee of the Red Cross on the “need for additional humanitarian international conventions.”⁸⁰³ In the midst of this experience, WHO neglected human rights frameworks as a strategy for health promotion.

This neglect for human rights occurred where WHO failed to involve its legal office in rights-based communications. For example, when the Division of Human Rights sought in 1966 to involve WHO in inter-agency reports on the Declaration on the Elimination of All Forms of Racial Discrimination,⁸⁰⁴ the legal office bristled at the suggestion that human rights were a part of its responsibility, with the Chief of the Legal Office noting “that the Legal Office has not been made ‘responsible’ for dealing with a particular activity solely on the grounds that it has legal aspects” and arguing: “I cannot really see any particular reason, based on the present functional description of Legal’s activities, why we should become responsible for preparing correspondence with the UN on the implementation of UN resolutions.”⁸⁰⁵ With such resistance to human rights from its legal staff, WHO would be hard pressed to assume a leadership role in legal rights, shirking this responsibility by finding legal rights to be “outside its competence.”

⁸⁰² United Nations General Assembly. Res. 2444 (XXIII). Respect for Human Rights in Armed Conflicts. 19 May 1969.

⁸⁰³ Letter from WHO Division of Co-ordination and Evaluation Director A. Bellerive to UN Division of Human Rights Director M. Schreiber. 4N64/372/1. 2 July 1969.

⁸⁰⁴ Letter from UN Division of Human Rights Director Marc Schreiber to WHO Director-General Marcolino G. Candau. SO 239 (5-1-2). 11 Oct. 1966.

⁸⁰⁵ Memorandum from WHO Chief of the Legal Office F. Gutteridge to Assistant Director-General Milton P. Siegel. 27 Oct. 1966.

When WHO finally came to discuss human rights in the 1970s, it did so clumsily—and, as a consequence, ineffectually—engaging in superficial and platitudinous statements unsuited to the interpretation and application of international human rights law.⁸⁰⁶⁻⁸⁰⁷ Primary health care under WHO’s Health for All Strategy was framed in human rights terms but with human rights depicted as a general humanitarian imperative rather than a specific legal obligation. Although the Declaration of Alma-Ata framed its programmatic obligations on the basis of a human right to health, it did so as a “social goal” 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. Whereas the ICESCR was developed with the expectation that specialized agencies would detail obligations pursuant to the rights within their respective purview,⁸⁰⁸ WHO did not seek to undertake this legal clarification with the Health for All strategy or Declaration of Alma-Ata. Where WHO legal officers saw “no direct link between article 12 [of the ICESCR] . . . and WHO standards,”⁸⁰⁹

⁸⁰⁶ Nájera E, Nájera P. Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379.

⁸⁰⁷ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁸⁰⁸ Alston P. The United Nations’ specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights, *Columbia Journal of Transnational Law*. 1979;18:79-118.

⁸⁰⁹ Letter from PAHO Legal Officer Alberto Rodriguez to Mark E. Battista. 3 Apr. 1981 (quoted in Battista ME. An enforceable human right to health: A new role for WHO. Sao Paulo Conference on the Law of the World, August 16-21. Washington: World Peace Through Law Center; 1981: 11).

WHO would see no need to set regulations to give meaning to this legal right. In the aftermath of the failure of the Declaration of Alma-Ata, critics argued that:

WHO's failure to encourage the development of precise legal standards with respect to the right to health is [] not only a violation of its constitutional mandate and its obligations as a specialized agency of the United Nations, but also of the institution's responsibilities under the Covenant on Economic, Social and Cultural Rights.⁸¹⁰

Without WHO human rights efforts to clarify this right through legal obligations, subsequent scholars have criticized the Health for All strategy as merely "dependent on goodwill" of national ministries, noting that "it is difficult to envisage such generality being an effective advocacy tool or being sufficiently specific to assess health policy and practice."⁸¹¹

As a result of these WHO weaknesses in engaging with the language of human rights, the right to health did not advance normatively to encompass underlying determinants of health, suffering a host of definitional problems, a lack of codification in national law, and an absence of concrete legal obligations and indicators necessary for its implementation. By the end of the 1970s, few states had codified a right to health in national constitutions,⁸¹² where such rights could form the basis of legal obligations for human rights enforcement. Even at the time of the Declaration of Alma-Ata, scholars

⁸¹⁰ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 45-46.

⁸¹¹ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King's College. London, England; 2001. 114, 140.

⁸¹² Page B. Socialism, health care and medical ethics. *Hastings Center Reports*. 1976;6(5):20.

had found the right to health to exist, at most, in so-called “soft law” – a status distinguished from that of binding international law by way of treaty or declaration.⁸¹³ Given WHO’s lack of appreciation for human rights development, scholars concluded in the wake of the Declaration of Alma-Ata that “an enforceable international legal right to health does not now exist,” reasoning that “while many instruments allude to the concept of health for all as an important principle very few purport to elevate the principle to the status of a legal norm.”⁸¹⁴

From the development of legal rights to the implementation of legal rights, WHO failed to employ its legal tools to guide and evaluate states in their efforts to implement human rights for underlying determinants of health. Where state reporting serves an instrumental enforcement mechanism in the implementation of human rights,⁸¹⁵ WHO’s abandonment of its role in monitoring state compliance and evaluating state reports proved detrimental to efforts to enforce a right to health. Although WHO developed evaluation recommendations for its Health for All campaign,⁸¹⁶ it did not apply this to or

⁸¹³ Dupuy. Introduction. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff. 1979.

⁸¹⁴ Battista ME. An enforceable human right to health: A new role for WHO. Sao Paulo Conference on the Law of the World, August 16-21. Washington, DC: World Peace Through Law Center. 1981: 1.

⁸¹⁵ Alston P. The United Nations’ specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights, *Columbia Journal of Transnational Law*. 1979;18:79-118.

⁸¹⁶ World Health Organization. *Global Strategy for Health for All by the Year 2000*. World Health Organization: Geneva. 1981.

through the right to health.⁸¹⁷ With international human rights norms weakened from their lack of WHO implementation, the definition of the right to health became an ambiguous entitlement without discrete standards. Even WHO staff were left to concede that implementation of the right to health requires states to take no concrete actions – only to “refrain from taking actions or omitting to take actions that will be detrimental to the progressive promotion” of the right.⁸¹⁸ As justified by a WHO legal officer in the aftermath of the Declaration of Alma-Ata, “[i]t is not for the WHO secretariat to state whether a framework between WHO standards and Article 12 is desirable or feasible. This is a question for Member States themselves to determine.”⁸¹⁹ Without formal WHO guidance, indicators of primary health care would not be enforced on states, and states would not supply public health data by which WHO could assess their implementation.⁸²⁰

With other international organizations taking an active role in “naming and shaming” states that failed to comply with human rights standards,⁸²¹ WHO continued to decline to review state reports submitted under the right to health, leaving states without guidance in implementing the right to health under the Declaration of Alma-Ata.

⁸¹⁷ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁸¹⁸ Eze OC. Right to health as a human right in Africa. In *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978*. Sijthoff & Noordhoff: Alphen aan den Rijn, The Netherlands. 1979. 76-93, 84.

⁸¹⁹ Letter from Mark E. Battista to WHO Director-General Halfdan Mahler. 5 Jan. 1982 (quoting WHO Legal Officer Rodriguez).

⁸²⁰ Kickbusch I. The development of international health policies — accountability intact?. *Social Science and Medicine*. 2000;51(6):979-989.

⁸²¹ Sand PH. Lessons learned in global environmental governance. *Boston College Environmental Affairs Law Review*. 1991;18:213-277.

Although WHO sought to cooperate with the Committee on Economic, Social and Cultural Rights in early 1980 by reporting on the rights covered by article 12 of the ICESCR,⁸²² this report focused exclusively on global issues of “generic implementation,” rather than on country-specific progress, and consequently was of little use to the Committee.⁸²³ Providing only general information on world health issues and WHO’s activities, this WHO report (unlike those other UN specialized agencies) neither assessed state reports⁸²⁴ nor “provide[d] precision to the scope of legal obligations under Article 12.”⁸²⁵ After this fleeting attempt to reengage with the UN to implement the ICESCR, WHO again removed itself from interagency work to realize the right to health in 1981, with WHO staff declining to comment on subsequent state reports and replying to the UN’s request for comment on implementation of the ICESCR by noting that (a) it has no mechanism for collecting information from states parties and (b) it is not in a position to appraise the reports of states parties.⁸²⁶ As a result of this lack of WHO involvement as an effective supervisory institution for the right to health, these state reports were completed sporadically, were poorly organized, and did not reflect health legislation and

⁸²² World Health Organization. Report on the right to health in Article 12 ICESCR. UN doc E/1980/24 22 Feb. 1980.

⁸²³ Trubek DM. Economic, social, and cultural rights in the Third World: Human rights law and human needs programs. In Meron T. *Human Rights in International Law: Legal and Policy Issues*. Clarendon: Oxford. 1984. 205-272: 244.

⁸²⁴ Mower AG. *International Cooperation for Social Justice: Global and Regional Protection of Economic/Social Rights*. Westport, Connecticut: Greenwood Press; 1985.

⁸²⁵ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 47.

⁸²⁶ Telegram from WHO CWO Chief O.W. Christensen to WHO Liaison to the UN. 4N64/372/3. 27 Jan. 1981.

implementing regulations.⁸²⁷ Given these responses in the years following the Declaration of Alma-Ata, scholars advocated that “[i]ncreased involvement of WHO – particularly as the body defining goals as standards and prescribing the actual steps to be taken to implement the standards – would support a cautious optimism regarding the transformation of the ideal of a right to health into the right to enjoy specific conditions that optimize potential for health.”⁸²⁸ However, WHO never propounded the Declaration of Alma-Ata, or any other WHO document, as providing standards by which states could implement the right to health.

With national human rights realization driven by definitiveness in international legal obligations, the ICESCR’s regression into ambiguity had proven fatal to national implementation of the right to health. Despite the Declaration of Alma-Ata’s goal to create programmatic definitiveness for the right to health, the completion of the Declaration did nothing to dispel the criticism that the right to health is “excessively broad in terms of operational implementation.”⁸²⁹ Reflecting on the meaning of this for the human right to health, legal scholars have noted that “[t]he potential effectiveness of the Covenant [ICESCR] in the protection and the promotion of the right to health has been undermined by WHO’s inadequate efforts to initiate the development of cogent international law standards and its insufficient efforts to report on national efforts to

⁸²⁷ See ECOSOC. Reports Submitted by States Parties Concerning Rights Covered by Articles 10 to 12. E/1980/6/Add.1-22.

⁸²⁸ Battista ME. An enforceable human right to health: A new role for WHO. Sao Paulo Conference on the Law of the World, August 16-21. Washington: World Peace Through Law Center; 1981: 12.

⁸²⁹ Nichols A. Ethics of the distribution of health care. *Journal of Family Practice*. 1981;12(3):533-538, 534.

implement the right pursuant to the Covenant.” Without WHO support for the clarification of legal rights for health, the lacunae of health rights would prove more meaningful than the substance of these rights, with activists left to decry the lack of WHO leadership and offer their own host of proposals for normative standards to respond to public health harms through human rights law.

2. International Law

With the UN created to be a forum for the progressive development of global standards and the codification of international law, UN specialized agencies were intended to extend this rule of law through independent international legal authority.⁸³⁰ Given this imperative to codify international legal standards through specialized agencies, WHO was endowed with expansive international lawmaking authority to fulfill its constitutional mandate, including in the WHO Constitution three separate articles to delineate WHO’s complementary authorities to draft regulations, conventions, and recommendations. At the time of WHO’s inauguration, legal analysts found that WHO “has been granted considerably greater operational autonomy and quasi-legislative powers than its predecessors possess,” with “procedures for ratification [] strengthened under the WHO Constitution to obtain the maximum possible adherence to international health agreements.”⁸³¹ Given these legislative powers beyond those of its institutional predecessors, WHO was designed to lead the development of international law as a

⁸³⁰ Schachter O. The role of international law in the United Nations. *New York Law Forum*. 1957;3:28-49.

⁸³¹ Allen CE. World health and world politics. *International Organization*. 1950;4(1):27-43: 31.

means to bind states to specific health measures and thus “to support, guide, and coordinate” national public health efforts.⁸³² Despite having these authorities for international legal regulation, however, WHO’s legal efforts continued along the narrow agenda of previous institutions of international health governance rather than moving beyond them to achieve the ambitious agenda for global health governance established in the WHO Constitution.

WHO’s first Director-General understood the expansive limits of WHO’s international legal authority, describing its constitutional powers for “opt-out” regulation as “a new principle of international law” that “will make health regulations adopted by the world Health Assembly far more effective than previous international conventions.”⁸³³ Complementing its early rights-based discourse, WHO sought an active role for international law to prevent disease and promote health, drawing on ILO’s convention mechanisms in its early years to adopt agreements and regulations that would bind member states in fulfilling their public health obligations unless they specifically opted out of them.⁸³⁴⁻⁸³⁵ The First International Sanitary Regulations of the World Health Organization, adopted in May 1951, were a monumental achievement in creating uniform state regulations for international disease protection, providing consistency and

⁸³² Bélanger M. The future of international health legislation. *International Digest of Health Legislation*, 1989;40(1):1-16:2.

⁸³³ Chisholm B. International health: The role of WHO, past, present, and future. *American Journal of Public Health*. 1951;41(12):1460-1463. 1460.

⁸³⁴ Skubiszewski K. Enactment of law by international organizations. *British Yearbook of International Law*. 1965;41:198-274.

⁸³⁵ Codding GA. Contributions of the World Health Organization and the International Civil Aviation Organization to the development of international law. *American Society of International Law Proceedings*. 1965;59:147-152.

universality to what had previously been scattered and haphazard state adoption of international legal regulations and also updating previously-antiquated quarantine regulations commensurate with current public health standards, disease threats, and means of transportation. Under this successful lawmaking experience, creating global health policy with widespread adherence and few state reservations, WHO worked closely with state delegates in “bringing the numerous countries hitherto fairly free to exercise arbitrary action under an up-to-date system of rules, and providing an efficient administration of this system and a machinery for keeping it up to date” through the coordinating authority of the WHO Secretariat.⁸³⁶

Despite WHO’s active exercise of its international legal authorities in its early years for the regulation of commerce in support of the public’s health—through binding International Sanitary Regulations, regulations on the nomenclature of diseases and death, and regulations on the purity of drugs in international trade—it eventually abandoned even these nascent international legal frameworks. Without developing new international legal standards to codify global health consensus, WHO sought to address health issues through direct action in the absence of legal frameworks.⁸³⁷⁻⁸³⁸ Describing this process in the early 1960s, WHO’s chief legal officer rationalized that:

The limited degree to which WHO has entered into the field of international legislation is due to a considerable extent to the difficulty of

⁸³⁶ Stowman K. International Sanitary Regulations. *Public Health Reports*. 1952;67(10):972-976. 974.

⁸³⁷ Health human rights and international law. *American Society of International Law Proceedings*. 1988;82:122-123.

⁸³⁸ Nielsen HK. *The World Health Organisation: Implementing the Right to Health*. Copenhagen: Europublishers; 1999.

drawing up and maintaining up-to-date international conventions, agreements or regulations on technical questions as well as to the differences in the scientific and technical development within its Member States.⁸³⁹

While other specialized agencies were producing copious international regulations and multilateral conventions to govern substantive issues within their respective purview,⁸⁴⁰ most prominently the wide-ranging international labor conventions developed by ILO member states, WHO long avoided such legislative and quasi-legislative lawmaking.

In spite of an early understanding of the crucial importance of international law in building cooperative mechanisms for global public health,⁸⁴² WHO rarely employed its authority to develop international law. With constitutional authority under article 21 to create binding international health regulations and under article 19 to draft international conventions, WHO long neglected these expansive authorities for underlying determinants of health. Article 21 of the WHO Constitution—granting regulation-making authority to WHO in international disease prevention, statistical standardization, and pharmaceutical safety—led to very few regulations,⁸⁴³ with many of these regulatory

⁸³⁹ Gutteridge F. The World Health Organization: Its scope and achievements. *Temple Law Quarterly*. 1963;37(1):1-14:11.

⁸⁴⁰ Commission to Study the Organization of Peace. *New Dimensions for the United Nations: The Problems of the Next Decade*. Dobbs Ferry, New York: Oceana Publications; 1966.

⁸⁴¹ Schachter O. The role of international law in the United Nations. *New York Law Forum*. 1957;3:28-49.

⁸⁴² Fidler DP. *International Law and Infectious Diseases*. Clarendon Press: Oxford; 1999.

⁸⁴³ World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*. Geneva:WHO; 1977.

standards subsequently reclassified as article 23 ‘recommendations,’ further weakening international standards. Reflecting on these missed opportunities for international law, scholars have noted that “[a]cross a wide variety of international health topics the World Health Organization has regarded it a prudent tactic to rely less on regulations and more on the authority of international biomedical consensus,” long understanding that this “recommendation-information-consensus-persuasion approach . . . may not in all instances be as effective as a formal international health regulation.”⁸⁴⁴ However, as justified by WHO at the height of its legislative absence, “[t]his procedure appears to be adequate . . . and it has the advantage of flexibility, since a recommendation may be modified or adopted without any formalities having to be observed.”⁸⁴⁵ Where binding regulations were applied, they took the form of International Health Regulations (IHRs, previously International Sanitary Conventions and International Quarantine Regulations).⁸⁴⁶ However, while these IHRs provided a valuable tool to WHO in directing international public health programs, WHO came to abandon even this basis of its work to nonbinding recommendations. Despite the detailed development of this international regulatory regime for disease prevention, the IHRs’ disease specificity (long covering only yellow fever, cholera, plague, and smallpox) left them unable to respond expeditiously to less prominent disease eventualities. As a result, “over the years there

⁸⁴⁴ Quimby FH. 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. Washington, DC: U.S. Govt. Print. Off.; 1971: 30-31.

⁸⁴⁵ World Health Organization. *The Second Ten Years of the World Health Organization*. Geneva: WHO; 1968: 299.

⁸⁴⁶ Tomasevski K. *Health*. In Schachter O, Joyner C. eds. *United Nations Legal Order*. 1995.

has been increasing emphasis on less formal means to combat the international spread of disease,”⁸⁴⁷ with WHO failing to enforce reporting requirements based on these regulations and the World Health Assembly long failing to consider any expansions of the regulations.⁸⁴⁸ Compounding the emptiness of this sparse legal landscape for international health, WHO’s expansive convention-drafting authority was never applied during the period under study. Under article 19 of the WHO Constitution, the World Health Assembly can adopt WHO Conventions or Agreements for any matter within WHO’s competence.⁸⁴⁹ Despite the promise of these article 19 conventions, this authority was never applied to public health in WHO’s early years,⁸⁵⁰ with WHO never considering the application of this authority to health until over fifty years of its existence had passed.⁸⁵¹⁻⁸⁵²

The inherent limitations of this non-legal approach became transparent in the failure to achieve rights-based reform through the Declaration of Alma-Ata. With WHO

⁸⁴⁷ Leive DM. *International Regulatory Regimes: Case Studies in Health, Meteorology, and Food*. Lexington, Mass: Lexington Books; 1976: 5.

⁸⁴⁸ Fluss SS, Gutteridge F. Some contributions of the World Health Organization to legislation. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. Plenum Medical Book Co.: New York; 1990.

⁸⁴⁹ *Constitution of the World Health Organization*. July 22, 1946. art. 19.

⁸⁵⁰ Gutteridge F. Notes on decisions of the World Health Organization. In Schwebel SM (Ed.). *The Effectiveness of International Decisions*. Oceana: Dobbs-Ferry, New York. 1971.

⁸⁵¹ Taylor AL. Making the World Health Organization work: A legal framework for universal access to the conditions for health. *American Journal of Law and Medicine*. 1992;18:301-346.

⁸⁵² Bodansky D. The Framework Convention/Protocol Approach, World Health Organization. Framework Convention on Tobacco Control Technical Briefing Services. WHO/NCD/TFI/99.1; 1999.

seeking no binding international law to codify the Declaration of Alma-Ata, instead focusing on non-binding recommendations to support its informal declarations, it was found that “WHO’s non-legal approach has undermined the potential effectiveness of the Health for All campaign.”⁸⁵³ With WHO’s 1981 adoption of Health for All by the Year 2000 failing to codify the obligations of the Declaration of Alma-Ata in international law, scholars came to doubt the possibility of harmonizing national health policies under international health legislation.⁸⁵⁴ Given this unwillingness to consider international legal obligations in achieving WHO’s health goals, even extremely popular international health campaigns such as the 1981 International Code of Marketing of Breast-Milk Substitutes were constructed as nonobligatory recommendations. Reflecting on this period, scholars have noted that:

During history’s greatest transformation of general international law, the harsh truth is that international law dropped off the agenda of global public health. International health law played no role, had no influence on, and was not influenced by the greatest changes ever seen in international law.⁸⁵⁵

Out of this failure to achieve the goals of WHO’s Health for All strategy, public health actors came to recognize the lost opportunities for international health legislation to

⁸⁵³ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 43.

⁸⁵⁴ Bélanger M. *Droit International de la Santé*. Paris: Economica; 1983.

⁸⁵⁵ Rajagopalan-Vorburger D. *World Health Organization and the Right to Health: A Legal Analysis of Its Interaction with Other Institutions*. Mémoire du Diplôme d’études supérieures en relations internationales. Université de Genève. Geneva, Switzerland; 2002: 31.

realize underlying determinants of health, and WHO has recently sought to employ international law for the public's health.⁸⁵⁶⁻⁸⁵⁷

3. National Legislation

As with international law, WHO did not consider national legislation to be a crucial part of state implementation of the human right to health. Without a national legislative strategy or model legal language as part of its Health for All campaign, states would not have the legislative capacity to develop law reforms, untethering states from the rule of law in rights-based health policy. Without the ability to codify the details of the Health for All strategy in law and create sustainable legal frameworks for primary health care, the weakened hortatory principles of the Declaration of Alma-Ata would enable state regression to the medicalized frameworks of selective primary health care.

WHO's early efforts toward an International Digest of Health Legislation⁸⁵⁸—drawn from earlier efforts by the Health Organization of the League of Nations and statutory obligations inherited from OIHP—failed where WHO did not communicate its relevance to states, and in turn, states did not respond to WHO with requested legislation for inclusion in the Digest. Despite early authority from the World Health Assembly to establish this survey of health legislation and publish it as a means to facilitate

⁸⁵⁶ *The Right to Health as a Human Right: Workshop, The Hague, 27-29 July 1978.* Sijhoff & Noordhoff: Alphen aan den Rijn, The Netherlands. 1979.

⁸⁵⁷ Fuenzalida-Puelma HL, Connor SS. *The Right to Health in the Americas: A Comparative Constitutional Study.* Washington: Pan American Health Organization; 1989.

⁸⁵⁸ World Health Assembly. Resolution 2.8. June 1949.

comparative public health law practice,⁸⁵⁹ this International Digest of Health Legislation did not find support in the WHO Secretariat. As a result, WHO soon came to neglect this effort, and most of the documentation published in the Digest came to it through informal networks of individual experts and independent research in UN libraries.⁸⁶⁰ Further, WHO did not request information on legislation or international agreements in states' annual health reports to WHO, with the World Health Assembly going so far as to suspend article 61 of the WHO Constitution, which had required states to report annually on the progress achieved in improving the health of their peoples.⁸⁶¹ In the absence of information applicable to health legislation, health ministries turned to health law analyses compiled in legislative surveys developed by other agencies.

In the early 1970s, WHO became concerned with its lack of initiative in health legislation.⁸⁶² However, this weakness was not immediately addressed in the Health for All campaign, as “the architects of the Health for All Strategy did not envision a critical role for the rule of law in implementing the international right to health” and, as a consequence, “the role of law in domestic societies has received little support from the organization.”⁸⁶³ The leadership of the WHO Secretariat belatedly brought this lack of

⁸⁵⁹ World Health Assembly. Resolution 3.15. May 1950; World Health Assembly. Resolution 3.63. June 1950.

⁸⁶⁰ Fluss SS, Gutteride F. Some contributions of the World Health Organization to legislation. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. New York: Plenum Medical Book Co.; 1990.

⁸⁶¹ WHO Executive Board. EB9.R70. Jan 1952.

⁸⁶² WHO Executive Board. EB47.R37. Jan 1971.

⁸⁶³ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 64-65.

attention to health legislation to the World Health Assembly in 1977,⁸⁶⁴ and in 1978, the WHO Secretariat sent a formal questionnaire to member states to request cooperation in reestablishing the Digest of Health Legislation, the responses to which required WHO to restructure the Digest to make it applicable to comparative health law practice and necessary legislative reforms in developing countries.

Based upon these state responses, WHO came to see the importance of public health legislation in influencing underlying determinants of health, including legislation for the first time in its 1978 Report on the World Health Situation.⁸⁶⁵ However, even in the midst of this recognition of health legislation in achieving WHO's Health for All strategy, the Declaration of Alma-Ata gives scant attention to the importance of implementing primary health care through the promulgation of national legislation, recommending only that:

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.⁸⁶⁶

⁸⁶⁴ World Health Assembly. Resolution 30.44. May 1977.

⁸⁶⁵ World Health Organization. *Sixth Report on the World Health Situation 1973-1977.* 57-63. Geneva: WHO; 1978.

⁸⁶⁶ WHO. *Primary Health Care: Report of the International Conference of Primary Health Care Alma-Ata, USSR, September 6-12 1978.* World Health Organization: Geneva. 1978.

Without the ability to apply national law for health rights, WHO suffered from an “implementation gap” in influencing national health ministries to develop appropriate systems for disease prevention and health promotion,⁸⁶⁷ with these national health ministries lacking the legal capacity to develop institutional reforms in the absence of WHO assistance.⁸⁶⁸ With institutional reforms requiring the coordination of the various national ministries implicated by underlying determinants of health, states would not possess the legal mechanisms for such multi-sectoral collaborations pursuant to the Declaration of Alma-Ata. While the Declaration of Alma-Ata referenced national legislation, this vague mention of national law did not hold prominence in the final Declaration and “makes no reference to preferred legislation or legal methods.”⁸⁶⁹ As criticized in the wake of the failure of the Declaration of Alma-Ata, “[r]ather than requiring countries to adopt the whole programme and thereby maintain the structural integrity of the Health-for-All programme, the WHO preferred to cajole and coax rather than utilise [sic] its powers.”⁸⁷⁰

The World Health Assembly did not seriously consider national health legislation until 1980.⁸⁷¹ Even in this process, although WHO developed twelve national indicators

⁸⁶⁷ Danida. *Effectiveness of Multilateral Agencies at Country Level: WHO in Kenya, Nepal, Sudan, and Thailand*. Ministry of Foreign Affairs: Copenhagen, Denmark. 1991.

⁸⁶⁸ Starrels JM. *The World Health Organization: Resisting Third World Ideological Pressures*. Heritage Foundation: Washington; 1985.

⁸⁶⁹ Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King's College. London, England; 2001: 115.

⁸⁷⁰ Id. at 114.

⁸⁷¹ WHO Executive Board. Resolution 13. EB65.R13. Jan 1980; World Helth Assembly. Resolution 33.28. May 1980.

under its 1981 Global Strategy for Health for all by the Year 2000,⁸⁷² these indicators had no basis in law, omitted entirely any mention of the importance of implementing legislation,⁸⁷³ and have been criticized where “most of the indicators are highly general and lack the specificity requisite to become the basis of law.”⁸⁷⁴ Given this lack of WHO emphasis on legal frameworks for national primary health care policy, few states promulgated legislation pursuant to the Declaration of Alma-Ata.⁸⁷⁵ Although WHO again sought to improve national reporting on health legislation in the early 1980s, this reporting procedure was not applied strictly, and national reporting waned in the years following the collapse of the Health for All strategy.⁸⁷⁶

Following this disregard for national legal implementation, WHO came to recognize this weakness and sought to use its technical cooperation program to strengthen national capacities for health legislation, employing consultants to draft enabling legislation for national primary health care systems and sponsoring conferences to promote the role of legislation as a tool for implementing health policy under the Health

⁸⁷² World Health Organization. *Global Strategy for Health for All by the Year 2000*. World Health Organization: Geneva. 1981.

⁸⁷³ Nájera E, Nájera P. Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379.

⁸⁷⁴ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 61.

⁸⁷⁵ Nájera E, Nájera P. Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379.

⁸⁷⁶ Fluss SS, Gutteride F. Some contributions of the World Health Organization to legislation. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. New York: Plenum Medical Book Co; 1990.

for All strategy.⁸⁷⁷ By 1984, WHO had prepared a resolution for the Executive Board and World Health Assembly to press states to “consider the desirability of enacting health legislation incorporating the basic principles of health for all.”⁸⁷⁸⁻⁸⁷⁹ With subsequent reviews of the progress of the Health for All strategy finding that “there are few countries that have expressly enacted legislation or legally binding regulatory instruments on which to base their activities to ensure the protection and care of the health of their peoples,” these retrospective legal analyses found that the Declaration of Alma-Ata “ought then to have included a point stressing the need for Member States to enact laws and other regulatory measures to give substance to these principles.”⁸⁸⁰ Although WHO would then set goals in 1987 for health legislation to implement primary health care, even its meager goal—50% of countries having health legislation supportive of national strategies of health for all—did not set standards for the content of national legislation or evaluative mechanisms to assess compliance.⁸⁸¹ Further, WHO’s technical consultations and conferences on health legislation would make no explicit connection between codification of public health law and realization of human rights for health. Although the European Regional Office came to address national legislation in fulfilling the Health for

⁸⁷⁷ Fluss SS, Gutteride F. Some contributions of the World Health Organization to legislation. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. New York: Plenum Medical Book Co; 1990.

⁸⁷⁸ World Health Assembly. Resolution. 37.17. ¶ 1(18). May 1984.

⁸⁷⁹ WHO Executive Board. EB73.R6. Jan. 1984.

⁸⁸⁰ Nájera E, Nájera P. Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379. 363.

⁸⁸¹ World Health Organization. *Evaluation of the Strategy for Health for all by the Year 2000: Seventh Report on the World Health Situation*. Geneva: WHO; 1987.

All strategy,⁸⁸² other regions failed to take any steps in national legal capacity-building. By 1993, WHO had acknowledged how its past legal omissions had contributed to the failure of the Declaration of Alma-Ata, recognizing “that such an ambitious goal as Health-for-All could not be achieved in the absence of an up-to-date, enlightened, and reasoned framework of laws, regulations, and other instruments...”⁸⁸³ Many developing states continued to lack the legislative capacity to develop national enabling legislation in the absence of appropriate legal models; however, unlike other international organizations, WHO did not create legislative models or undertake legal capacity-building.⁸⁸⁴

Given these weaknesses in applying law, WHO has been left without a major tool for applying human rights to health policy, crippling efforts to apply the rule of law in implementing the right to health and in codifying the provisions of the Health for All strategy in national legislation.

C. Elevation of Medical Care over Health Rights

“Social security cannot be fully developed unless health is cared for along comprehensive lines...”

- Sir William Beveridge, 1942

⁸⁸² Pinet G. The WHO European program of health legislation and the Health for All policy. *American Journal of Law and Medicine*. 1988;12:441-460.

⁸⁸³ World Health Organization. *Implementation of the Global Strategy for Health for All by the Year 2000: 8th Report on the World Situation*. Geneva: WHO; 1993: 55.

⁸⁸⁴ Taylor AL. Making the World Health Organization work: A legal framework for universal access to the conditions for health. *American Journal of Law and Medicine*. 1992;18:301-346.

In the course of the development and implementation of the right to health, the WHO Secretariat repeatedly disclaimed responsibility for human rights by arguing that it was a “technical organization.” Implicit in this disclaimer was the belief of WHO staff that WHO’s pragmatic approach to medical care was incompatible with a rights-based vision to underlying determinants of health. Given ambiguities in the language of the right to health—ambiguities largely caused by WHO’s lack of participation in the evolution of legal norms—the right to health was left open to shifting definitions of the very object of the right, with the medical establishment holding the primary authority to define health and the programs necessary to realize it. In WHO’s frequent invocation of the shibboleth of technical programming, WHO allowed its medical approach to health to influence implementation of the right to health in a way that encompassed primarily physicians and the practice of medicine. With its technical agenda focused on the provision of medicines and the training of medical practitioners, WHO’s programs would not give sufficient attention to underlying determinants of health, with the rise of physicians in health discourse leading to a medicalization of health and human rights within WHO.

Since before the creation of WHO, there has been widespread understanding in health discourse that the public’s health is a function of underlying determinants of health rather than medical care; and yet these individual medical technologies became a mainstay of the right to health rather than the collective primary health care systems necessary for disease prevention and health promotion. Physicians within WHO resisted a focus on underlying determinants of health and a policy driven by the Declaration of Alma-Ata where “[c]onservative attitudes among health professionals led to perceptions

of PHC [primary health care] as anti-intellectual and non-scientific in its proposed solutions to health problems.”⁸⁸⁵ With the right to health supporting primary health care—a low-technology approach to resource-poor populations with limited medical personnel—WHO physicians would remain skeptical of human rights as a means to achieve WHO’s Health for All campaign.⁸⁸⁶ As a result, the medical model persisted in WHO despite evidential consensus, memorialized in the Declaration of Alma-Ata, supporting the necessity of primary health care systems to address underlying determinants of health.

Despite its constitutional role in global health and its awareness of various human rights programs, WHO did not act to give content to the right to health or assist in its implementation, deferring to medicine rather than leading in human rights.⁸⁸⁷ Fixing blame on WHO, others noted that “WHO has not taken the leadership role [in human rights] despite the fact that it is the appropriate vehicle, procedurally and practically.”⁸⁸⁸ In the wake of failure of the Declaration of Alma-Ata, scholars noted that “inadequate national commitment 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.”⁸⁸⁹ It was not, however, a failure to secure national dedication but a failure of

⁸⁸⁵ Lee K. *The World Health Organization*. London: Routledge; 2009: 79

⁸⁸⁶ Brody EB. *Biomedical Technology and Human Rights*. Paris: UNESCO; 1993.

⁸⁸⁷ Battista ME. An enforceable human right to health: A new role for WHO. Sao Paulo Conference on the Law of the World, August 16-21. Washington, DC: World Peace Through Law Center. 1981: 2.

⁸⁸⁸ Id. at 17.

⁸⁸⁹ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991: 42.

WHO to define and implement international rights consistent with public health discourse on underlying determinants of health. Not until it was too late, WHO chose to avoid this human rights imperative, denying its health recommendations the moral suasion of the right to health.

1. Rise of the Medical Establishment

The right to health was codified during a unique and unrepresentative moment in the history of ideas surrounding health. As WHO worked with states to develop the right to health in international law, discourses on health rights veered away from underlying determinants of health and toward curative health care during and immediately following the Second World War.⁸⁹⁰⁻⁸⁹² In rebuilding a world shattered by war, there was a sense that science would provide the foundation upon which a new world would be built,⁸⁹³ encapsulated in the UDHR's promise of an individual right "to share in scientific advancement and in its benefits." The medical establishment would play a prominent role in this new global vision for health technologies. 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—this era is part of what has come to be known as the "golden age of

⁸⁹⁰ Sigerist HE. *Medicine and Human Welfare*. New Haven: Yale University Press; 1941.

⁸⁹¹ Milbank Memorial Fund. *Backgrounds of Social Medicine*. New York: Milbank Memorial Fund; 1949.

⁸⁹² Goodman NM. *International Health Organizations and Their Work*. London: J&A Churchill; 1952.

⁸⁹³ World Health Organization. *The First Ten Years of the World Health Organization*. Geneva: World Health Organization; 1958.

medicine.”⁸⁹⁴ From this medicalized conception of health, rooted in the scientific spirit of the post-War era, these rights to health and medical science were created simply as a right to the individual medical treatments then thought to be singularly necessary to bring about the perceived “end of disease”⁸⁹⁵ and achieve the highest attainable standard of health.

The medicalization of the right to health parallels the rise of the medical establishment. Prior to the First World War, public health practitioners held far greater sway over national and international health policy, emphasizing national efforts to develop social, political, and economic environments conducive to health. Physicians during this period had little expert training and served few medical functions beyond surgery, suffering from widespread suspicions of their reliability in promoting health.⁸⁹⁶ To the degree that medicines existed, they were largely unregulated elixirs with unproven effects. With the advent of federal regulation of pharmaceuticals in the United States, followed thereafter by regulations in other developed states and international regulations through the League of Nations’ Commission on Biological Standardization, governmental institutions arose to control the production and distribution of those products marketed as medicines. This increased regulation would “put into law the notion that the scientific approach—not the commercial, not the anecdotal, not the

⁸⁹⁴ Turner BS. The interdisciplinary curriculum: From social medicine to postmodernism. *Society, Health & Illness*. 1990;1:5-7.

⁸⁹⁵ Tenner E. *Why Things Bite Back: Technology and the Revenge of Unintended Consequences*. New York: Vintage; 1997: 74.

⁸⁹⁶ Rosen G. *From Medical Police to Social Medicine: Essays on the History of Health Care*. 1974.

approach based on authoritative opinion—would be the standard for modern society.”⁸⁹⁷

By the end of the 1930s, this adherence to standards in drug development and investment in pharmaceutical science would lead to dramatic medical breakthroughs in the control of disease and promotion of health.⁸⁹⁸ The Second World War would highlight the unlimited possibilities of scientific medicine in improving health.

With this technological success came a newfound legitimacy for the medical profession: “Whereas many ‘practitioners’ prior to the legalization of medicine enjoyed a most dubious recognition and social position, this changed rapidly from the moment that its technological advances were able to purport its assertions to be the saving discipline of man.”⁸⁹⁹ With the medical establishment reaching new heights in social standing and policy participation in states throughout the world—creating an “aristotechnocracy” built upon the superiority of technological expertise in solving global problems—the world’s physicians, bound together by social and systemic solidarity, employed bonds of global mutual identification to create the international legal institutions governing a medically-driven view of healthcare.⁹⁰⁰ Medical practitioners saw a place to advance the cause of medicine through human rights. Given physicians’ longstanding antipathy to public health as a form of “socialized medicine”—finding such non-medical political, social, and economic interventions antithetical to improving the public’s health—these

⁸⁹⁷ Hilts PJ. *Protecting America’s Health: The FDA, Business, and One Hundred Years of Regulation*. New York: Knopf; 2003: 93.

⁸⁹⁸ Sigerist HE. *Medicine and Human Welfare*. New Haven: Yale University Press; 1941.

⁸⁹⁹ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979: 196.

⁹⁰⁰ Id.

physicians would bring national governments to focus their health efforts on medical interventions.⁹⁰¹

In the aftermath of the War, with medical therapies cutting into the spread of infectious diseases under nascent national health services and with genetics providing a framework for considering health to be biologically, not socially, driven, public health programs began to lose relevance and were displaced by the medical profession's individual treatments.⁹⁰² As the gatekeepers of biomedical technologies, these technology-oriented physicians would have a disproportionate, paternalistic role in deciding how scientific applications would be allocated and administered for health through the rise of national health services.⁹⁰³ With developed states (except the United States) creating insurance systems for medical care in the 1940s and 1950s, designing these insurance schemes to emphasize medical practice over public health and social medicine,⁹⁰⁴ it was largely assumed that the same hospital-based model of medical provision would form the basis of health care in the developing world.⁹⁰⁵ Despite a meteoric rise in research on underlying determinants of health in the international public health literature, expanding understandings of health through budding social scientific

⁹⁰¹ Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SW, Mansourian PB, Davies AM, Piel A (Eds.). *Understanding the Global Dimensions of Health*. 15-33. New York: Springer. 2005.

⁹⁰² Taylor AL. Controlling the global spread of infectious diseases: Toward a reinforced role for the International Health Regulations. *Houston Law Review*. 1997;33:1327-1362.

⁹⁰³ Brody EB. *Biomedical Technology and Human Rights*. Paris: UNESCO. 1993.

⁹⁰⁴ Porter D. (Ed.). *Social Medicine and Medical Sociology in the Twentieth Century*. 97-113. Amsterdam-Atlanta, GA: Rodopi B.V.; 1997.

⁹⁰⁵ Grant JB. International trends in health care. *American Journal of Public Health*. 1948;38:381-397.

inquiry,⁹⁰⁶ the medical establishment remained obstinately disconnected from these public health discourses.⁹⁰⁷ Ignoring calls to give medical practitioners “the same level of clerkship and internship in social as in clinical medicine,”⁹⁰⁸ the global medical establishment would continue to focus solely on curative care in a hospital setting. Within WHO, these medical discourses manifested themselves in investigations of medical care as a driver of public health,⁹⁰⁹ avoiding any acknowledgement of the importance of public health systems and underlying determinants of health throughout WHO’s early development.⁹¹⁰

2. WHO & the Medicalization of Health

The WHO Secretariat adopted this medicalized approach to health in the 1950s and early 1960s, opposing examinations of underlying determinants of health in the context of its medical programs and excluding social medicine viewpoints in the

⁹⁰⁶ E.g., Hanlon JJ. A bookshelf on international health. *American Journal of Public Health*. 1958;48(4):413-424.

⁹⁰⁷ Allen RB. *Medical Education and the Changing Order*. New York: Commonwealth Fund; 1946.

⁹⁰⁸ Grant JB. International trends in health care. *American Journal of Public Health*. 1948;38:381-397. 394.

⁹⁰⁹ Roemer M. *Medical Care in Relation to Public Health: A Study of Relationships between Preventive and Curative Health Services Throughout the World. Prepared at the Request of the World Health Organization and revised by WHO and ILO Secretariats*. Geneva: WHO. 1956.

⁹¹⁰ Litsios S. The Christian Medical Commission and the development of the World Health Organization’s primary health care approach. *American Journal of Public Health*. 2004;94(11):1884-1893.

implementation of its eradication campaigns.⁹¹¹ With public health and social medicine thought to be a product of the pre-pharmaceutical era, WHO came to support medical interventions and vertical disease eradication programs. WHO staff understood that the vast majority of those in the developing world were beset by a paralyzing assault of chronic poverty and endemic disease, but WHO's defense against these cumulative onslaughts was sought only through medical services and personnel, with a programmatic focus on infectious disease eradication and medical training in poor regions.⁹¹² Even in attempts to revitalize discussion of underlying political determinants of health in WHO's early years, WHO's first Director-General framed these political determinants by their effect on access to health technology, arguing that:

Certain conditions tend to prevent effective transplantation of *health techniques*—such conditions as unstable government, obsolete land tenure systems, nepotism, insecurity of tenure of civil servants, political appointments to technical positions, ignorance, sacred cows of many colors, shapes, and sizes and under many names, poverty, low productivity, graft and corruption, irresponsibility in using international relationships for internal political purposes, excessive nationalism,

⁹¹¹ Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SW, Mansourian PB, Davies AM, Piel A (Eds.). *Understanding the Global Dimensions of Health*. 15-33. New York: Springer. 2005.

⁹¹² Mani C. International health: Application of WHO programs and policies in a region. *American Journal of Public Health*. 1951;41:1469-1472.

excessive birth rates, and extensive misrepresentation of facts and of motives.⁹¹³

Although many progenitors of WHO lamented the abandonment of concern for underlying determinants of health,⁹¹⁴ WHO would institutionally support medical frameworks, with this medical view constraining the right to health to that which could be performed by physicians – medical care.

With WHO and international development organizations ignoring previously-recognized societal determinants of health,⁹¹⁵ these organizations championed a biomedical vision of health that emphasized antibiotics, medical technologies, and large, centralized, private urban hospitals.⁹¹⁶ This medical vision, driven by the larger “medical-industrial complex” that had sprung from the Second World War,⁹¹⁷ formed the backbone of WHO’s public health efforts during the 1950s and 1960s. With WHO viewing public health as the aggregate of individual health status (rather than a composite whole that is greater than the sum of its parts and addressed through the provision of public goods), WHO would come to view its public health work merely as a transition from individual physician-patient relationships to hospital-based medical care. For

⁹¹³ Chisholm B. International health: The role of WHO, past, present, and future. *American Journal of Public Health*. 1951;41(12):1460-1463: 1461 (emphasis added).

⁹¹⁴ Stampar A. Background to Rural Health. Geneva: WHO; 1954.

⁹¹⁵ Porter D. The decline of social medicine in Britain in the 1960s. In Porter D. (Ed.). *Social Medicine and Medical Sociology in the Twentieth Century*. 97-113. Amsterdam-Atlanta, GA: Rodopi B.V.; 1997.

⁹¹⁶ Golub ES. *The Limits of Medicine: How Science Shapes Our Hope for the Cure*. Chicago: University of Chicago Press; 1994: 215.

⁹¹⁷ Ehrenreich B, Ehrenreich J. *The American Health Empire: Power, Profits and Politics*. New York: Vintage; 1970.

example, with the World Health Assembly requesting a study in 1953 on “the relationships between public health, medical care and social security,”⁹¹⁸ the WHO Secretariat’s response focused overwhelmingly on the “medical care” aspect of its charge, reviewing hospital-based administration of health services to the exclusion of governmental systems to address underlying determinants of health.⁹¹⁹ To the extent that disease and disability existed in rural communities outside of the reach of these large urban hospitals, WHO sought only to build the capacity of national health ministries to undertake vertical disease prevention programs in these communities rather than to establish comprehensive primary health care systems.⁹²⁰ Given this attempt to address public health through the expansion of welfare systems to provide medical services for the poor, WHO’s focus on curative care over the social, political, and economic determinants of health left WHO rigidly corseted by its focus on medical personnel rather than public health systems.

Even when WHO sought to shed its focus on individual medical treatments in the late 1960s, with the failure of WHO’s eradication campaigns blamed on their exclusive focus on medicine to the disadvantage of public health systems, the medicalized focus (and medical training) of Secretariat staff limited them in engaging with human rights for underlying determinants of health. WHO’s focus in its Health for All Strategy was

⁹¹⁸ World Health Assembly. Resolution 5.73. 1953.

⁹¹⁹ Roemer M. *Medical Care in Relation to Public Health: A Study of Relationships between Preventive and Curative Health Services Throughout the World. Prepared at the Request of the World Health Organization and revised by WHO and ILO Secretariats.* Geneva: WHO. 1956.

⁹²⁰ Candau MG. World health catalysts. *American Journal of Public Health.* 1957;47(6):675-681.

driven by its Director-General, who had a long personal understanding of (and experience with) primary health care interventions in improving the public's health; however, these understandings and convictions were not shared by the physicians making up the Secretariat staff. As a result, physicians would be ill equipped to develop or implement the primary health care focus of the Declaration of Alma-Ata.

The Declaration of Alma-Ata sought to redefine health so that it would no longer be seen as synonymous with medicine.⁹²¹ Rather than training more doctors and equipping more hospitals, the Declaration of Alma-Ata agreed to the simple preventive methods of public health to achieve health promotion through an emphasis on underlying determinants of health. But this consensus would be implemented through health ministries, leading proponents of the Declaration of Alma-Ata to rail that “[t]rying to promote primary health care through the medical profession is like trying to promote land reform through the big landowners.”⁹²² Ironically, WHO never enlisted political actors in implementing the Declaration of Alma-Ata, undercutting its own discourse on political determinants of health by reaching out only to parochial national health ministries rather than those with the political authority to reform intersectoral national policy for primary health care. The elite physicians within national health ministries—unaccustomed to theories on underlying determinants of health and indignant toward a public “right and duty to participate” in health decision-making—would be hard pressed to follow the nonmedical precepts of the Declaration of Alma-Ata. With medical training failing to

⁹²¹ World Health Organization. *From Alma-Ata to the Year 2000: Reflections of the Midpoint*. Geneva: WHO; 1988.

⁹²² Taylor D. The chance of a lifetime. *World Health*. 1983(Sept.):2-5:5 (quoting David Werner, Director of The Hesperian Foundation in Palo Alto, California, USA).

adapt to an emphasis on primary health care and without physician elites appreciating social determinants of health, physician practice and policy returned to an emphasis on expensive curative care, applied selectively to a privileged few through medical technologies and hospital-based services.⁹²³ It was not until the mid-1980s that a consensus of WHO personnel, having trained in public health, came to recognize that the Organization's focus on curative and rehabilitative medicine had imperiled state disease prevention and health promotion efforts through medicine's disproportionate draw on national health funding and human resources.

3. The Medicalization of Human Rights

Physicians inside and outside of WHO saw the right to health as a drawback to selective medical care, actively opposing efforts to move beyond medical care in clarifying the scope and content of health rights.

From the origins of a right to health, physician groups would object to the budding health and human rights movements as a means to address underlying determinants of health, with the World Medical Association objecting to human rights treaties generally and the American Medical Association objecting to WHO interference in domestic medical practice. With the latter focusing its wrath on human rights provisions for underlying determinants of health, the American Medical Association argued before the U.S. Congress that “[t]he socio-economic aspects of medical practice

⁹²³ Green RH. Politics, power and poverty: Health for All in 2000 in the third world?. *Social Science and Medicine*. 1991;32:745-755.

should be the concern of the individual country.”⁹²⁴ With U.S. physicians having already beaten back both Roosevelt’s and Truman’s domestic efforts to create a universal health insurance program,⁹²⁵ they would extend to international forums this well-funded advocacy of “personal freedom” against “socialized medicine.” In noting the antipathy of the U.S. medical establishment to WHO’s proposed role in social medicine, the U.S. Surgeon General at the time of WHO’s founding and representative to the International Health Conference subsequently advised that the rise of national health services “causes more concern in the breasts of organized medicine in this country than does the spread of Communism to a senator from Wisconsin [Joseph McCarthy].”⁹²⁶ While these organizations proved willing to develop deontological postulates for physicians, they never concerned themselves with international law for patients; while they would guide biomedical research, they would not address underlying determinants of health.⁹²⁷

Even once a right to health was established in international law, physician organizations would link this right to medicine. In this context, the World Medical Association would continue to construe this right as a right merely “to receive the best available medical care,” and would not press even for recognition of this fragmentary

⁹²⁴ Hearings of the Committee on Foreign Affairs, Subcommittee on National and International Movements, House of Representatives, 13, 17 June, 3 July 1947.

⁹²⁵ Peon M. *Harry S. Truman Versus the Medical Lobby*. Columbia: University of Missouri Press; 1979.

⁹²⁶ Parran T. Milestones in public health. *West Virginia Medical Journal*. 1950;46:1-16.

⁹²⁷ Lador-Lederer JJ. Promotion of health: The making of an international norm. *Israel Yearbook on Human Rights*. 1988;18:121-152.

right.⁹²⁸ With the United States turning in the 1970s to consider a right to health, the U.S. terms-of-debate on the right to health would be normatively limited to ideological demands for health care for the poor, with advances in medical science leading social justice theorists to argue for medical care as a fundamental need that could then be provided universally at some minimum level, highlighting systems analogous to those in Europe as a means of assuring more equitable medical services.⁹²⁹ As a result, physicians focused on a right to health as an individual right to medical services—seeking to create a “decent minimum” of medical care based on individual choice and personal responsibility⁹³⁰—rather than as a governmental duty to realize underlying determinants of health on an equitable basis. Despite an understanding among social justice scholars that health was societally rather than individually driven, requiring redistributive justice as a means to reach for equity in underlying determinants of health, this medical debate endured, excluding physicians from human rights discourses on the political, economic, and social conditions that structure the public’s health.

Given this physician intransigence, WHO—driven by the conservative organizational culture of medicine—abandoned human rights as a tool for health and then employ it only to the provision of medicine. With physicians unwilling to engage in human rights, WHO focused on “technical” programmes rather than “legal rights.” These WHO discourses through the 1960s would emphasize medical care, medical

⁹²⁸ Lador-Lederer JJ. Promotion of health: The making of an international norm. *Israel Yearbook on Human Rights*. 1988;18:121-152:134.

⁹²⁹ E.g., Sidel VW, Sidel R. *A Healthy State: An International Perspective on the Crisis in United States Medical Care*. New York: Pantheon Books; 1977.

⁹³⁰ Fried C. Equality and rights in medical care. *Hastings Report*. 1976;6:29-34.

training, and medical practitioners, viewing the “manpower” challenge as the most pressing health priority.⁹³¹ Human rights would play little role in these discourses, with WHO seeking through informal recommendations to provide medical services through government payment rather than merely religious charity.⁹³² As a result, WHO never brought to fruition rights-based health programs, either in its own international work or the creation of national health policies. Unlike other international agencies’ vast human rights education campaigns,⁹³³ WHO neglected to support education on a human right to health, failing to raise the consciousness of activists and cultivate public opinions in ways that would influence political elites to pay heed to human rights in health policy. With WHO declining to participate in anniversary celebrations of the UDHR or in human rights seminars, health advocates would lack access to the human rights norms employed in other fields to shift public opinion and reform national policies.

Left without a public health framework for health rights, the ICESCR memorialized perennially an ambiguity in the very object of the right,⁹³⁴ fixing the definition of health upon contemporary assumptions that such a definition included only

⁹³¹ Wolstenholme G, O’Connor M. *Health of Mankind: Ciba Foundation 100th Symposium*. Boston: Little, Brown and Company. 1967.

⁹³² Roemer M. *Medical Care in Relation to Public Health: A Study of Relationships between Preventive and Curative Health Services Throughout the World. Prepared at the Request of the World Health Organization and revised by WHO and ILO Secretariats*. Geneva: WHO; 1956.

⁹³³ Henkin L. *How Nations Behave: Law and Foreign Policy*. New York: Columbia University Press; 1979.

⁹³⁴ Daniels N. *Just Health Care*. Boston: Cambridge University Press; 1985.

measures for medical care.⁹³⁵ Compounding this medicalization through WHO negligence, the UDHR's right "to share in scientific advancement and in its benefits" was little changed to the ICESCR's right "to enjoy the benefits of scientific progress and its applications." This medicalization of the right to health would be extended through international human rights norm development on Human Rights in Light of Scientific & Technological Developments, pressing WHO to react in opposition to international discourses in opposition to science and technology in the 1968 Teheran Human Rights Conference and leading states to shift international legal language away from the human rights harms of science and technology and to focus on the human rights benefits of science and technology for health. As a result of WHO's failure to pursue policy preferences for the public's health, the language of the right to health was weakened, moving away from underlying determinants of health. Unlike the social medicine focus of the Constitution of the World Health Organization,⁹³⁶ this right to health in the ICESCR would be operationalized as a right to medicine and medical services,⁹³⁷ suggesting that "a right claim to equal *health* is best construed as a demand for equality of access or entitlement to health *services*."⁹³⁸ This obligation of conduct toward the

⁹³⁵ King M. Personal health care: The quest for a human right. In *Human Rights in Health* 227-238. Ciba Foundation Symposium Series; 1974.

⁹³⁶ *Constitution of the World Health Organization*. July 22, 1946.

⁹³⁷ King M. Personal health care: The quest for a human right. In *Human Rights in Health* 227-238. Ciba Foundation Symposium Series; 1974.

⁹³⁸ Daniels N. Just Health Care. Boston: Cambridge University Press; 1985: 7.

individual, rather than an obligation of result to the public, diminished the importance of collective primary health care systems.⁹³⁹

As a result of this medicalized path for the right to health, WHO's success in framing human rights as a means to realize its Health for All strategy would not extend through the Declaration of Alma-Ata. WHO would not implement the rights to public participation that flowed through the Declaration of Alma-Ata, relying on expert opinion rather than the consensus of those seeking to benefit from primary health care.⁹⁴⁰ Although WHO program officers would come to state in the aftermath of the Declaration of Alma-Ata that "the basic right to health is the special responsibility of WHO, and the Organization has striven from the outset to put the relevant aims of the Declaration [UDHR] in practice in its programs,"⁹⁴¹ this historical revision did little to overcome WHO's longstanding blindness to human rights in its health programming before the Declaration of Alma-Ata. Because the WHO Secretariat assumed no formal responsibility in implementing the Declaration of Alma-Ata, these program officers would lack credibility based upon their previous neglect of rights-based efforts to pursue subsequent rights-based efforts to persuade states to take action to create primary health care systems.

⁹³⁹ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979: 198.

⁹⁴⁰ Kweyuh P. Health for whom by when? A view from Kenya. *World Health Forum*. 1996;17:346-347.

⁹⁴¹ Gunn S.W.A., Emergency Relief Operations, World Health Organization. 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*. Torino, Italy. 20-21 May 1983: 113.

VI. Conclusion – Legacies of WHO Neglect

Given the failure of the Declaration of Alma-Ata, WHO's leadership in health rights has been displaced by the influence of international economic institutions, with WHO's mission for health and human rights dispersed among other UN agencies and intergovernmental organizations.⁹⁴² These economic institutions, providing weighted voting based on financial contribution, provided far greater representation for the interests of the developed world in global health governance,⁹⁴³ replacing the constructivist vision of ideational rights development with the realist vision of state power struggles. WHO had leadership authority to coordinate these economic agencies for health promotion within the UN, but scholars have found that despite “considerable opportunity for dialogue with the WHO, the operational and policy independence of these organizations from the coordinating ‘authority’ of WHO is palpable.”⁹⁴⁴ With funding for international health goals shifting away from the UN and towards international development agencies,⁹⁴⁵⁻⁹⁴⁶ this expansion of organizations with purview over health has complicated efforts to develop universal normative adherence to WHO’s uniform system

⁹⁴² Silver G. International health services need an interorganizational policy. *American Journal of Public Health*. 1998;88:727-729: 728.

⁹⁴³ Zacher MW, Keefe TJ. *The Politics of Global Health Governance: United by Contagion*. Palgrave MacMillan; 2008.

⁹⁴⁴ Howard L. The evolution of bilateral and multilateral cooperation for health in developing countries. In Reich MR, Marui E (Eds.) *International Cooperation for Health: Problems, Prospects, and Priorities*. Dover, Mass.: Auburn House. 1989; 332-357:351.

⁹⁴⁵ World Bank. *Financing Health Services in Developing Countries: An Agenda for Reform*. Washington: World Bank. 1987.

⁹⁴⁶ Paul JCN. The United Nations and the creation of an international law of development. *Harvard International Law Journal*. 1995;36:307-328.

of public health practices memorialized in the Declaration of Alma-Ata. It became clear that there was an enormous and growing gap between the acceptance of the universal principles of the Declaration of Alma-Ata and the implementation of those rights-based principles through national primary health care systems.⁹⁴⁷ By 1988, WHO conceded the impossibility of its initial primary health care agenda, postponing its Health for All goals, removing the language of “by the Year 2000” from its “Health for All” campaign, and renaming its delayed vision of health justice as “Health for All in the 21st Century.”⁹⁴⁸

As a result of this medicalization of primary health care and dilution of health leadership among international organizations, a limited individual right to health—thereafter interpreted solely as a right to medical care⁹⁴⁹ or right to health protection⁹⁵⁰—has constrained rights-based advocates to pressing for discrete individual health services for problems necessitating social change through public health systems.⁹⁵¹ In the wake of WHO’s 1980s exclusion as a legitimate actor in human rights implementation, WHO thereafter skirted its continuing obligations to monitor periodic national reports on the right to health pursuant to the ICESCR, referring to its early 1980 report as its final word

⁹⁴⁷ Tarimo E, Webster EG. *Primary Health Care Concepts and Challenges in a Changing World: Alma-Ata Revisited*. Geneva: WHO. 1994.

⁹⁴⁸ World Health Assembly. Strengthening Primary Health Care. WHA Res. 41.34. 13 May 1988.

⁹⁴⁹ Roemer R. The right to health care. In Fuenzalida-Puelma HL, Connor SS. *The Right to Health in the Americas: A Comparative Constitutional Study*. Pan American Health Organization: Washington. 1989. 17-23.

⁹⁵⁰ *Il Diritto alla Tutela della Salute: Acts of the International Colloquium on the Right to Health Protection*. Torino, Italy. 20-21 May 1983.

⁹⁵¹ Meier BM, Mori LM. The highest attainable standard: Advancing a collective human right to public health. *Columbia Human Rights Law Review*. 2005;37:101-147.

on the right to health,⁹⁵²⁻⁹⁵³ and relegated health rights to the discretion of other specialized agencies.⁹⁵⁴ With states seeking to further human rights for health in the absence of guidance from WHO Secretariat headquarters, these rights-based treaties would be framed in the language of “patient’s rights” to medical care.⁹⁵⁵

When WHO again took up the reigns of human rights in the late 1980s, this human rights mandate was framed solely in the language of negative rights (e.g., discrimination, stigma) and limited to the unique circumstances of the HIV/AIDS pandemic.⁹⁵⁶⁻⁹⁵⁷ Given WHO’s abnegation of leadership to other organizations, with WHO criticized for “diminishing its role just at the time when the world is looking for health leadership,”⁹⁵⁸ WHO could not even retain leadership authority for the global response to HIV, with the UN taking the Global Programme on AIDS from WHO’s purview in 1993 to create a separate bureaucracy in UNAIDS, a move described as “an

⁹⁵² Letter from WHO Division of Coordination Director John L. Kilgour to UN Division of Human Rights Director Theo C. van Boven. CWO-4N64/418/2. 25 Mar. 1980.

⁹⁵³ Taylor AL. *The World Health Organization and the Right to Health*. LLM Thesis. Columbia Law School. New York, New York; 1991.

⁹⁵⁴ E.g., UNESCO. *International Symposium on the Effects on Human Rights of Recent Advances in Science and Technology*. Barcelon, Spain, 25-28 March 1985. Paris: UNESCO; 1985.

⁹⁵⁵ E.g., World Health Organization Regional Office for Europe. *Draft European Declaration on the Rights of Patients*. Copenhagen: WHO; 1989.

⁹⁵⁶ World Health Organization. Global strategy for the prevention and control of AIDS. WHA Res. 40.26. 1987.

⁹⁵⁷ Mann JM. The World Health Organization’s global strategy for the prevention and control of AIDS. *West J Med*. 1987;147(6):732–734.

⁹⁵⁸ Godlee F. WHO in retreat: Is it losing its influence? *British Medical Journal*. 1994;309:1491-1495.

institutional ‘slap in the face,’ an expression of the loss of faith by donor governments in the organization’s [WHO’s] capacity to lead a global disease campaign.”⁹⁵⁹ (Although this inter-agency HIV/AIDS agenda has since encompassed positive rights of access to lifesaving medications,⁹⁶⁰ this framework has nevertheless proven inadequate to address growing socioeconomic disparities in underlying determinants of health pursuant to human rights standards.⁹⁶¹) Without WHO involvement, this ‘negative rights for health’ paradigm was extended through reproductive health, with both the 1994 International Conference on Population and Development in Cairo and 1995 UN Conference on Women in Beijing emphasizing information and empowerment as a means to achieve health.⁹⁶² Despite an ostensible end to the “artificial” division between positive and negative rights at the conclusion of the Cold War, an end memorialized in the 1993 Vienna Declaration and Programme of Action,⁹⁶³ the Vienna Declaration’s holistic language—proclaiming the ‘interrelation’ and ‘interdependence’ of all rights—masked a predominance of negative rights within WHO.

⁹⁵⁹ Lee K. *The World Health Organization*. London: Routledge; 2009. 62.

⁹⁶⁰ Forman L. Ensuring reasonable health: Health rights, the judiciary, and South African HIV/AIDS policy. *Journal of Law, Medicine & Ethics*. 2005;33(4):711-724.

⁹⁶¹ Hein W, Kohlmorgen L. Global health governance: Conflicts on global social rights. *Global Social Policy*. 2008;8(1):80-108.

⁹⁶² Dempsey RA, Meier BM. Going negative: How reproductive rights discourse has been altered from a positive to a negative rights framework in support of ‘women’s rights’. In Murthy P, Smith CL. Eds. *Women’s Global Health and Human Rights*. Jones & Bartlett: New York; 2009.

⁹⁶³ Vienna Declaration and Programme of Action, Report of the World Conference on Human Rights. Vienna, Austria: United Nations; 1993.

It was during this period—with the hegemony of the neoliberal economic paradigm necessitating 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.⁹⁶⁴⁻⁹⁶⁵ The neoliberal economic paradigm—including policy prescriptions for privatization, deregulation, and decentralization—has led to the dismantling of national health systems and the reorientation of economic development to the detriment of developing states, exacerbating health inequities within and between countries.⁹⁶⁶ Thus, while globalization has resulted in improvements in technology and health services for a chosen few in the developed world, various globalized economic processes (as exemplified in the causal mechanisms outlined below) have robbed individuals of the autonomy to exercise health rights and governments of the strength to fulfill them:

Process	Mechanism
Shared Health Dilemmas	<p>Double Disease Burden</p> <ul style="list-style-type: none"> Infectious disease—resulting from global trade and travel, infectious diseases (among them AIDS, SARS, and drug-resistant tuberculosis)—has spread rapidly throughout the world, disregarding national and regional boundaries Noncommunicable diseases (from harmful food, water, and housing) <i>and</i> also chronic diseases (such as cardiovascular disease, cancer, and diabetes) have resulted from inequitable development
Poverty and Inequitable Development	<ul style="list-style-type: none"> Neoliberal development policies are correlated with widening financial inequalities—and, correspondingly, health gaps—within states and among states in the developed and developing world Even where societies experience growth at the national level, additional economic increases do little to improve the health of the general population

⁹⁶⁴ Tarantola D. A perspective on the history of health and human rights: From the Cold War to the gold war. *Journal of Public Health Policy*. 2008;29:42–53.

⁹⁶⁵ Mahler H. *Forward*. In MacDonald TH. *Health, human rights and the United Nations: Inconsistent aims and inherent contradictions?*. Oxford: Radcliffe Publishing; 2008.

⁹⁶⁶ Meier BM, Fox AM. Development as health: Employing the collective right to development to achieve the goals of the individual right to health. *Human Rights Quarterly*. 2008;30:259-355.

	<ul style="list-style-type: none"> when this wealth is not shared across society Given the billions living on less than \$2/day, extreme poverty has led to dire consequences for poverty-related disease—including undernourishment and a lack of access to safe drinking water and basic sanitation—and a “high death/high birth” population dynamic
Deterioration of the Built Environment	<p>Changes in the Built Environment</p> <ul style="list-style-type: none"> Migration — migration harms health where individuals from rural areas, seeking employment or escape, have migrated at unprecedented rates to urban centers that lack the infrastructure to support such influxes Employment — the rapid introduction of market-oriented policies has led to a bifurcation of employment opportunities and forced many to seek employment in informal economies Housing — slum housing is plagued by inadequate sanitation and infrastructures, creating conditions associated with significant decreases in healthy outcomes
Weakening of Public Health Systems	<p>Structural Adjustment Programs</p> <ul style="list-style-type: none"> Crippling of state health programs — structural adjustment programs have left many developing welfare states without the health systems and technologies necessary to respond to the majority of the world’s disease burden Weakening of regulations that protect health — developing governments, already under pressure to privatize, face enormous obstacles in making the long-term budgetary commitments necessary for improvements in public health and health care systems
Increasing Influence of Transnational Corporations	<ul style="list-style-type: none"> Exploiting new markets — through the threat and practice of relocation, transnational corporations have stymied national efforts to regulate their behavior, pushing states toward creating regulatory safe-havens for their operations Damaging environments/Creating dangerous products — the rise in inequitable trade and unregulated industrialization of the developing world, driven by transnational corporations, has led to local and global environmental health problems while creating products damaging to the public’s health⁹⁶⁷

In the wake of neoliberal economic reforms, exposing developing states to exorbitant national debt repayments and damaging structural adjustment programs, the broad definition of primary health care systems laid out in the Declaration of Alma-Ata has been replaced with one that focuses on narrow, vertical, curative interventions in the context of national health system retrenchment, reduced health expenditure, and widening health inequalities. With developing nations undertaking structural adjustment to service economic debts to the developed world, these states have been pressed to reduce health

⁹⁶⁷ Meier BM. Employing health rights for global justice: The promise of public health in response to the insalubrious ramifications of globalization. *Cornell Int'l L. J.* 2006;39:711-777.

sector financing for comprehensive primary health care and focus on selective hospital-based services.⁹⁶⁸ As a result, the 1980s saw a drop in public health spending, particularly in developing countries,⁹⁶⁹ which saw the steepest percentage decline in central government expenditure.⁹⁷⁰ Rather than opposing this paradigm under the legal mantle of health rights, “WHO has fallen victim to neoliberal globalization,”⁹⁷¹ forced into public-private partnerships and extra-budgetary programs for assuring individual health care instead of primary health care for the public’s health.⁹⁷² These partnerships and programs—distorting WHO priorities, institutionalizing vertical health provision, and detracting from primary health care systems—have further reduced WHO’s mission and ability to influence global health.⁹⁷³ As developing states reduced health expenditures, health inequalities widened. Consequently, even WHO was 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.”⁹⁷⁴ Despite repeated WHO efforts to address

⁹⁶⁸ Cornia GA. Economic decline and human welfare in the first half of the 1980s. In Cornia GA, Jolly R, Steward F (Eds.). *Adjustment with a Human Face, Vol. I: Protecting the Vulnerable and Promoting Growth*. Oxford:Clarendon Press; 1987:11-47.

⁹⁶⁹ E.g., Grosh ME. Social spending in Latin America: the story of the 1980s. World Bank Discussion Paper No. 106. 1990.

⁹⁷⁰ World Health Organization. *From Alma-Ata to the Year 2000: Reflections at the Midpoint*. Geneva: WHO; 1988.

⁹⁷¹ Letter from Alison Katz to WHO Director-General Margaret Chan. Jan. 2007.

⁹⁷² MacDonald T. *Health, Trade and Human Rights*. Oxford: Radcliffe Publishing; 2005.

⁹⁷³ Horton R. WHO: The casualties and compromises of renewal. *Lancet*. 2002;359:1605-1611.

⁹⁷⁴ Millen J, Irwin A, Kim JY. Introduction: What is growing? Who is dying?. In Millen J, Irwin A, Kim JY, Gershman J. eds. *Dying for Growth: Global Inequality and the*

disparities in medical care, “[m]any developing countries did not...enjoy the benefits of improved public health capabilities experienced in the developed world.”⁹⁷⁵ By yielding power without the concomitant transfer of responsibility, WHO’s loss of control to public-private partnerships has denied health programs the transparency, accountability, and representation necessary to assure the realization of health rights.

Without access to international legal standards for underlying determinants of health, WHO could credibly be denied a seat at the multi-sectoral development table,⁹⁷⁶ disengaging it from the global socioeconomic institutions most crucial to realizing improvements in public health.⁹⁷⁷ Given the weaknesses of WHO’s rights-based approach in alleviating the harmful ramifications of neoliberal globalization policies through health systems,⁹⁷⁸ WHO returned to economic analysis to engage development discourse and persuade national governments to increase vertical, disease-specific health spending merely as a means to achieve macroeconomic growth.⁹⁷⁹⁻⁹⁸¹ Health advocates,

Health of the Poor. Common Courage Press: Monroe, Maine. 2000; 4 (quoting WHO Director-General Gro Harlem Brundtland).

⁹⁷⁵ Fidler DP. *International Law and Infectious Diseases*. Clarendon Press: Oxford; 1999. 12.

⁹⁷⁶ Lee K, Collinson S, Walt G, Gilson. Who should be doing what in international health: A confusion fo mandates in the United Nations?. *British Medical Journal*. 1996;312:302-307.

⁹⁷⁷ Meier BM, Fox AM. Development as health: Employing the collective right to development to achieve the goals of the individual right to health. *Human Rights Quarterly*. 2008;30:259-355.

⁹⁷⁸ Kirby M. The right to health fifty years on: Still skeptical?. *Health & Human Rights*. 1999;4(1):6-25.

⁹⁷⁹ Abel-Smith B. The economics of health care. In Lambo TA, Day SB. Eds. *Issues in Contemporary International Health*. Plenum Medical Book Co.: New York; 1990.

not accustomed to working with WHO in development for health equity or employing human rights norms for the public's health, abandoned legal obligations altogether, relegating themselves to the moral suasion of non-obligatory international discourse through the UN's 2000 Millennium Development Goals (MDGs)⁹⁸² and UNAIDS and WHO's "3 by 5" program for the distribution of HIV medications.⁹⁸³ 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, causing a further shift away from the promise of Health for All.⁹⁸⁴

At the close of the twentieth century, no standards would exist to give specificity to the goals of the human right to health, denying guidance in crafting implementing regulations. Despite a 2003 UN effort to develop among specialized agencies a Common Understanding on a Human Rights-Based Approach to Development Cooperation,⁹⁸⁵ WHO has not sought to operationalize this Common Understanding through a rights-based approach to health through development.

⁹⁸⁰ Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO; 2001.

⁹⁸¹ Waitzkin H. Report of the WHO Commission on Macroeconomics and Health: A summary and critique. *Lancet*. 2003;361:523-526.

⁹⁸² United Nations. *Millennium Development Goals*. 2000. Available at <http://www.un.org/millenniumgoals/index.html>.

⁹⁸³ WHO. *Treating 3 Million by 2005: Making It Happen: The WHO Strategy*. Geneva: WHO. 2004.

⁹⁸⁴ Litsios S. The health, poverty, and development merry-go-round: The tribulations of WHO. In Gunn SW, Mansourian PB, Davies AM, Piel A (Eds.). *Understanding the Global Dimensions of Health*. 15-33. New York: Springer. 2005.

⁹⁸⁵ United Nations. *The Human Rights-Based Approach to development Cooperation Towards a Common Understanding Among the UN Agencies*. New York: UN; 2003.

In the absence of strong historical support from WHO for human rights obligations to uphold its goals for underlying determinants of health, it has fallen to modern human rights institutions—the Committee on Economic, Social and Cultural Rights⁹⁸⁶⁻⁹⁸⁷ and subsequently, the UN Special Rapporteur on the Right to Health⁹⁸⁸—to do what WHO could not: interpret the right to health in an expansive way that would set legal standards for state public health indicators in accordance with the spirit and obligations of the Declaration of Alma-Ata. With WHO having long since abandoned its role in reporting on the right to health to the Committee on Economic, Social and Cultural Rights, the Committee was delayed in creating a General Comment on the right to health, and in doing so, was hard pressed to interpret the right to health in the absence of an historical record. Given past WHO neglect in these evolving discourses, such an interpretation required an explicit acknowledgement of the “dynamic definition of the right to health”⁹⁸⁹ and a *de novo* attempt to interpret the right to health commensurate

⁹⁸⁶ Committee on Economic, Social and Cultural Rights. Ninth session. Summary Record of the Forty-Second Meeting, 6 December 1993. E/C.12/1993/SR.42. 23 Nov. 1994.

⁹⁸⁷ 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. General Comment No. 14, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22nd Sess., Agenda Item 3. U.N. Doc. E/C.12/2000/4; 2000.

⁹⁸⁸ *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. ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10. U.N. Doc. E/CN.4/2003/58. 13 Feb. 2003.

⁹⁸⁹ Committee on Economic, Social and Cultural Rights. Ninth session. Summary Record of the Forty-Second Meeting, 6 December 1993. E/C.12/1993/SR.42. ¶ 7 (Comments of WHO representative). 23 Nov. 1994.

with evolving health discourses.⁹⁹⁰ To the extent that these efforts in normative expansion have faced criticism for exceeding the limits of their legal mandate for normative clarification,⁹⁹¹⁻⁹⁹² constraining these interpretations in influencing state policy, these limitations on international legal obligations for WHO's Health for All strategy can be traced back over fifty years, when WHO lost its human rights compass and struggled thereafter to find its way back to a human right to health.

⁹⁹⁰ 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. General Comment No. 14, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22nd Sess., Agenda Item 3. U.N. Doc. E/C.12/2000/4 (2000).

⁹⁹¹ Goodman T. Is there a right to health? *Journal of Medicine and Philosophy*. 2005;30:643-662.

⁹⁹² Gorove K. Shifting norms in international health law. *American Society of International Law Proceedings*. 2004; 98:18-19.

Afterword

Human rights evolve. As dynamic concepts, these rights are politically constructed by international actors to create the capabilities for a life with dignity. For health, human rights can be seen to advance in response to changing health threats, theories, and technologies. Yet this evolution in human rights is mediated by international institutions that dictate the development and implementation of human rights through the UN. In the case of health, WHO has both the authority and the capacity to lead the evolution of human rights for the prevention of disease and promotion of health. Were WHO to seize this human imperative, it could develop human rights to address underlying determinants of health unaccounted for by contemporary human rights law, responding to the insalubrious harms of globalization through the codification of a collective human right to health.

Globalization has fundamental implications upon individual and public health. State implementation of neoliberal economic policies has resulted in the escalation of endemic diseases and the rapid proliferation of infectious and chronic diseases. Globalization has brought with it changes to both the underlying determinants of health and the health care and research necessary to meet challenges to health. In ways detrimental to health, economic globalization has brought with it the reemergence of infectious disease and the exacerbation of chronic disease. These broad changes to the underlying determinants of health have taken health status outside of the control of the individual. With the right to health set out as an individual right, it has been incapable of responding to societal underlying determinants of health.

Given an extended period of WHO neglect, an individual right to health is incapable of speaking to these changing global conditions. This is the paradigm that WHO briefly, albeit unsuccessfully, sought to shift through its collective interpretation of a right to health in its Health for All strategy:

When in May 1977 the Health Assembly gave expression to its view that “health is a basic human right and a worldwide social goal,” the objective of an individual human right liable to individualistic interpretation in the liberal sense and resulting in solution or responses at the personal level at last began to merge with the social goal for the community or sum of individuals, a social goal which includes the individual but can no longer bear a personal interpretation, since it demands a community approach in which it is the common interest of all that must prevail.⁹⁹³

Nevertheless, anachronistic notions of health doggedly continue to pervade human rights discourses, influencing developing state responses to health dilemmas. The Western medicalized vision of a right to health, as a human right, has been transplanted onto health systems throughout the world.⁹⁹⁴ Despite decades of advocacy in the field of public health, the right to health has been ineffective in altering state health policies or infrastructures. Because the right to health is consistently set forth in general, aspirational language that describes the ultimate goal but not the “actions that member

⁹⁹³ Nájera E, Nájera P. Gili-Miner M. Health for all as a strategy and the role of health legislation: Some issues and views. *International Digest of Health Legislation*. 1986;37(2):362-379. 364-365.

⁹⁹⁴ Pannenborg CO. *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care*. Alphen aan den Rijn, The Netherlands: Sijthoff & Noordhoff; 1979: 84

nations must take,”⁹⁹⁵ the treaty language provides little guidance as to the specific scope of states’ obligations under the right to health.⁹⁹⁶⁻⁹⁹⁷ Consequently, few have been able to argue that the right to health has created any norm of customary international law, binding all states to specific public health actions in upholding health goals.⁹⁹⁸

This lingering paradigm of individual health, focused on a right to individual medical care, is no longer applicable to a globalizing world, compelling a renewed focus on the collective societal factors that facilitate the spread of disease. Controlling the spread of disease will require a set of rights commensurate to combating the harmful public health effects of neoliberal policies. Through an emphasis on the underlying societal determinants of health, it becomes clear that the human right sought to be protected is a collective right. Rather than relying solely upon an individual right to medical care, envisioning a collective right to public health—employing the language of human rights at the societal level—would alleviate many of the injurious health inequities of globalization.

The Universal Declaration of Human Rights provides that “everyone is entitled to a social and international order in which the rights and freedoms set forth in this

⁹⁹⁵ Taylor AL. Making the World Health Organization work: A legal framework for universal access to the conditions for health. *American Journal of Law and Medicine*. 1992;18:301-346. 327.

⁹⁹⁶ Fidler DP. *International Law and Infectious Diseases*. Oxford, United Kingdom: Clarendon Press; 1999.

⁹⁹⁷ Fidler DP. “Geographical morality” revisited: International relations, international law, and the controversy over placebo-controlled HIV clinical trials in developing countries. *Harvard International Law Journal*. 2001;42:299-354.

⁹⁹⁸ Kinney ED. The international human right to health: What does this mean for our nation and world?. *Indiana Law Review*. 2001;1457-1475.

Declaration can be fully realized.”⁹⁹⁹ While rarely recognized by scholars of the UDHR, this international order is particularly relevant for facilitating the UDHR’s promise of health rights: “*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.” Creating the “social and international order” necessary to uphold a right to public health will require international structures for facilitating cooperation in public health programs.¹⁰⁰⁰ Health rights demand international cooperation.¹⁰⁰¹ Under an expansive right to health and public health, each state bears an obligation to assist other states in addressing global health disparities. The Committee on Economic, Social and Cultural Rights’ General Comment on the right to health lends credence to this interpretation of health rights, with the Committee “emphasis[ing] that it is particularly incumbent on State parties and other actors in a position to assist, to provide ‘international assistance and cooperation, especially economic and technical’ which enable developing countries to fulfil their core and other obligations.”¹⁰⁰² Such cooperation can be fulfilled through state participation in public health lawmaking within WHO.

⁹⁹⁹ *Universal Declaration of Human Rights*. G.A. Res. 217A(III), U.N. GAOR, 3d Sess., at 71, U.N. Doc. A/810; 1948: art. 28.

¹⁰⁰⁰ Flinterman C. Three generations of human rights. In *Human Rights in a Pluralist World*.

¹⁰⁰¹ Nielsen HK. *The World Health Organisation: Implementing the Right to Health*. Copenhagen: Europublishers; 1999.

¹⁰⁰² 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. General Comment No. 14, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22nd Sess., Agenda Item 3. U.N. Doc. E/C.12/2000/4 (2000): ¶ 45.

Whereas the right to health has been resistant to change, the structure and operation of the WHO have proven far more malleable to changes in international affairs and public health theory. Since the early medicalized days of the WHO, a product of the inclusion of states largely from the developed world, the WHO has become inclusive, almost universally so, leading to a resurgence of interest in developing national socioeconomic determinants underlying health.¹⁰⁰³ With developing states coming into being and entering as member states of the WHO, the organization has changed to include broad collective public health measures in place of individual health technologies. This was seen most clearly in the shift from an emphasis on individual infectious diseases in favor of multilateral health assistance to strengthen national health services. Through these national capacity-building programs for health, WHO has served to strengthen national public health systems in responding to collective health threats.

For those globalized determinants of health beyond the territorial confines of the state, international lawmaking offers states the opportunity to work cooperatively to uphold health rights, challenging the globalization of disease through the “globalization of public health.”¹⁰⁰⁴ As states have become largely impotent to prevent disease through domestic legislation and regional organizations, international health law has become necessary to impose obligations on states and provide the global public health

¹⁰⁰³ WHO Commission on the Social Determinants of Health, Knowledge Network on Health Systems. Available at: http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf [Accessed 18 Aug 08].

¹⁰⁰⁴ Yach D, Bettcher D. Globalisation of tobacco industry influence and new global responses. *Tobacco Control*. 2000;9:206-212.

infrastructure necessary to confront the globalization of disease.¹⁰⁰⁵ In response to globalization, many international organizations will need to explore multilateral health governance structures as a means to safeguard public health. Although the “failure of the internationalization of public health” is one of the primary pathologies of the re-emergence of infectious and noninfectious disease,¹⁰⁰⁶ both the revised International Health Regulations and WHO’s Framework Convention on Tobacco Control¹⁰⁰⁷ have shown states the benefits of international law in the field of health policy, permitting effective multilateral public health measures to combat global disease. Through these delegations to WHO and restructuring of the extant contract between WHO and its member states, states have been able to overcome domestic and collective-action problems to achieve a common good, setting a valuable precedent for future international delegation in public health.

As with infectious diseases and tobacco, the processes of globalization have exacerbated many global health challenges while leaving individual states and regional bodies incapable of responding effectively in the absence of an institutionalized means of interstate cooperation. While showing some success in uniting state public health responses under international law, WHO has been unable to effectuate international health law under a unified framework of human rights. To create this rights-based

¹⁰⁰⁵ Fidler DP. The globalization of public health: The first 100 years of international health diplomacy. *Bulletin of the World Health Organization*. 2001;79:842-847.

¹⁰⁰⁶ Fidler DP. *International Law and Infectious Diseases*. Oxford, United Kingdom: Clarendon Press; 1999: 17.

¹⁰⁰⁷ WHO Framework Convention on Tobacco Control, W.H.A. Res. 56.1, World Health Assembly, 56th Ass., 4th plen. mtg, Agenda Item 13, Annex, WHO Doc. A56.VR/4 (May 21, 2003), http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf.

approach through WHO, a right to public health would galvanize states to work together through international law and WHO to overcome collective threats to global health. Justifying public health controls under the authority of a human right to public health would provide WHO action with the normative framework necessary to address globalization's harms to the underlying determinants of health.

WHO has never before approached international lawmaking through human rights frameworks, denying its public health strategies the legal obligations necessary for their effectiveness. In particular, WHO has rarely approached health issues under the right to health.¹⁰⁰⁸ Although international treaties recognize an international right to health, the right is frequently criticized for being “so broad that it lacks coherent meaning and is qualified by the principle of progressive realization.”¹⁰⁰⁹ This may be due, in part, to the fact that the right to health, as an individual human right, cannot speak to the provision of public goods such as public health.¹⁰¹⁰ As a result, despite WHO’s constitutional commitment to human rights, it has nevertheless been criticized for failing to operationalize human rights principles.¹⁰¹¹ To meet these obligations, states must develop the legal mechanisms under a collective right to public health to facilitate international flows of research, assistance, and cooperation, augmenting the role of WHO in the development of global public health infrastructures.

¹⁰⁰⁸ Chapman A, Russell S. *Core Obligations: Building a Framework for Economic, Social, and Cultural Rights*. New York, NY: Intersentia; 2002.

¹⁰⁰⁹ Fidler DP. *International Law and Infectious Diseases*. Oxford, United Kingdom: Clarendon Press; 1999: 197.

¹⁰¹⁰ Chander A. Globalization and distrust. *Yale Law Journal*. 2005;114:1193-1236.

¹⁰¹¹ Nielsen HK. *The World Health Organisation: Implementing the Right to Health*. Copenhagen: Europublishers; 1999.

A collective human right to public health, providing national goals and measurement indicators, would alleviate these difficulties in applying health rights through international law. Through the preamble to the WHO Constitution, states have declared that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, *economic or social condition*,” giving WHO the authority to examine health in its broadest conception: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁰¹² This conception of health necessitates examination of the underlying determinants of health through a rights framework, an opportunity not taken with the International Health Regulations and FCTC.¹⁰¹³ Justifying public health controls under the authority of a human rights framework would provide WHO action with the normative framework necessary to address globalization’s harms to the underlying determinants of health. By applying international Regulations, Conventions, and Agreements to public health, the World Health Assembly can create binding regulation to buttress a human right to public health while adjusting to changing health conditions through delegation to the WHO Secretariat.

In providing for implementation of the international dimensions of a right to public health, the WHO can work within the ICESCR enforcement framework in reviewing and commenting upon country reports, gleaning from these national reports

¹⁰¹² *Constitution of the World Health Organization*. July 22, 1946. Preamble.

¹⁰¹³ Meier BM. Breathing life into the Framework Convention on Tobacco Control: Smoking cessation and the right to health. *Yale Journal of Health Policy, Law and Ethics*. 2005;5:137-192.

areas of common need that warrant international regulation. Pursuant to article 22 of the ICESCR,

The Economic and Social Council [the supervisory body of the Committee on Economic, Social and Cultural Rights] may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.¹⁰¹⁴

This is particularly important in the realization of health rights, where highly technical state public health reports may be undecipherable by the human rights staff of the Committee on Economic, Social and Cultural Rights. Although the WHO has not taken advantage of its authority under this provision of the ICESCR, a right to public health, moving health rights toward a recognition of global public goods, would provide the impetus necessary for WHO to employ its unique expertise in health to corroborate and evaluate state reports and coordinate international responses based upon those reports.

Such an expanded mandate for the WHO Secretariat will require a diminished role for WHO's regional organizations. These regional organizations, a product of both Cold War divisions and antiquated understandings of disease regionalization, are not responsive to the growing globalization of disease and health risk. This traditional

¹⁰¹⁴ International Covenant on Economic, Social and Cultural Rights. United Nations General Assembly. Resolution 2200A (XXI). 16 Dec. 1966. Art. 22.

decentralization of international health law has stymied regional cooperation in public health. Because of a reflexive overreliance on the principles of sovereignty and subsidiarity, health responses best served through global cooperation have been left to languish at the national and regional level, allowing disease to fester untreated and retarding global responses.¹⁰¹⁵ These regional offices have become too politicized and unresponsive to global health concerns, leading to inefficient responses. To give the leadership at WHO headquarters the notice, preparation, and resources to respond globally to pandemic disease and adapt quickly to changes in medical technology for health promotion, it is necessary that states, acting through the World Health Assembly, establish a standardization of regional offices and preference for centralizing the WHO's response to global health issues.

Leadership from the WHO Secretariat is necessary to make this response a reality. A right to public health can be a guide in framing that response. In reviewing WHO country reports under articles 61 through 65 of the WHO Constitution, the WHO Secretariat can examine each state law, regulation, official report and epidemiological statistic through the lens of a right to public health. This, in turn, would provide a harmonization in public health law necessary to assure equality both within and among states. Such a centralized response, however, would not prove to denigrate cultural concerns as some critics fear, but rather would allow for the same standards to be applied in accounting for these cultural, social, political, and economic concerns pursuant to the principle of progressive realization. Further, the WHO Secretariat can apply a right to public health in fulfilling its interpretive role for regulations, conventions, and

¹⁰¹⁵ Godlee F. The regions – Too much power, too little effect. *British Medical Journal*. 1994;309(6968):1566–1570.

agreements. By examining threats to public health for what they are—violations of human rights—public health practitioners can build upon WHO’s nascent international mechanisms to challenge global threats and realize justice in health.

Finally, WHO should advance an independent international legal framework under its monitoring. WHO has authority to draft international law under its constitution,¹⁰¹⁶ an authority exercised in the FCTC. Similar to the FCTC—and a recently advocated Framework Convention on Global Health¹⁰¹⁷—member states could create a series of international legal documents to clarify state obligations to provide for primary health care systems. Where states have not ratified previous human rights treaties for reasons outside of the right to health, such WHO treaty law would provide these states with the ability to assent to obligations under the right to public health and adhere to standards otherwise unratified. Similar to the complementary agencies created to monitor national compliance with international environmental commitments,¹⁰¹⁸⁻¹⁰¹⁹ WHO could create compliance, capacity-building, and harmonization of ‘best practices’ in state adherence with a right to public health. Through its international organization bureaucracy, the WHO Secretariat could coordinate state action and manage evolving legal norms to create robustness in state implementation of this new right.

¹⁰¹⁶ *Constitution of the World Health Organization*. July 22, 1946. art. 19.

¹⁰¹⁷ Gostin LO. Meeting basic survival needs of the world’s least healthy people: Toward a Framework Convention on Global Health. *Georgetown Law Journal*. 2008;96: 331-392.

¹⁰¹⁸ Chayes AH, Chayes A, Mitchell RB. Active compliance management in environmental treaties. In Lang W (Ed.). *Sustainable Development and International Law*. 75-90. London, England: Graham & Trotman. 1995.

¹⁰¹⁹ E.g., UN, *Agenda 21: Programme of Action for Sustainable Development*. New York, New York: United Nations. 1993.

Health rights do not evolve without the normative support of WHO; WHO's health goals do not progress without the legal obligations of health rights.

After decades of neglect for human rights, with repeated criticism of WHO for its lack of coordination in the field of human rights, Secretary-General Annan's 1997 "Renewing the United Nations: A Programme for Reform"—explicitly mandating a cross-cutting approach to human rights within the UN, by which specialized agencies are to "mainstream" human rights in all programs, policies and activities¹⁰²⁰—has paved the way for WHO to incorporate human rights into its public health efforts. Under Director-General Harlem Brundtland, WHO would take up this UN call, seeking to mainstream human rights in its activities and, in doing so, reestablish WHO as "the world's health conscience."¹⁰²¹ In the wake of this rights-based approach to global health governance, a growing scholarly chorus rallied around the right to health, concluding that:

WHO would benefit substantially from adoption of the right to health as its underlying crosscutting policy and that such an approach would also be equally important to the further conceptualization of the right to health.

Having the WHO as advocate and protector of the right to health would enable the concept to develop in a positive and supported manner and yet remain grounded to ensure it has practical effect.¹⁰²²

¹⁰²⁰ United Nations. Renewing the United Nations: A Programme for Reform. Report of the Secretary-General. U.N. GAOR. 51st Session. UN Doc. A/51/950. 1997.

¹⁰²¹ Lee K. The pit and the pendulum: Can globalization take health governance forward?. *Development*. 2004; 47(2):11-17.

¹⁰²² Lakin AE. *The World Health Organisation and the Right to Health*. PhD Dissertation. King's College. London, England. 2001: 7.

With a decade under this cross-cutting approach, WHO has only just begun to implement its tenets, most prominently through the 2003 development of its rapidly-evolving Department of Ethics, Trade, Human Rights and Health Law, which has prominently collaborated with organizations, scholars, and advocates at the intersection of health and human rights. Despite the initial fanfare surrounding its inauguration, however, this human rights office has faced attrition in its budget and prominence, with nascent WHO international legal frameworks facing criticism for their disconnection from the path of human rights.¹⁰²³ Given this sinuous spirit for human rights within WHO, it remains to be seen whether WHO will adhere to this evolving UN mandate or, as has been done in the wake of so many previous admonitions, revert to its institutional isolation and human rights abnegation.

Only by appreciating the rich history of WHO involvement with health rights are we able to recognize the squandered opportunities for WHO leadership to advance a rights-based approach to health – and to learn from those lost opportunities.

¹⁰²³ Conrad C, Jong L, Vestal G. *Background Paper: Tobacco Control and Human Rights, A Human Rights-Based Approach to Tobacco Control*. Human Rights and Tobacco Control Network Conference. Lausanne, Switzerland. August 2008.

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